Department of State Hospitals

2024-25

Governor's Budget
Proposals and Estimates

Submitted to:
California Department of Finance
January 10, 2024

Department of State Hospitals
2024-25 Governor's Budget
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6. Infectious Disease Prevention	$ -	0.0	$ 25,900	10.0	
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DEPARTMENT OF STATE HOSPITALS
PROGRAM OVERVIEW
Informational Only

BACKGROUND

The California Department of State Hospitals (DSH) manages the nation's largest inpatient forensic mental health hospital system. The mission of DSH is to provide evaluation and treatment to patients in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings. Within the context of the broader mental health system of care, DSH primarily serves individuals who have been committed to the Department through the superior courts or Board of Parole Hearings. Additionally, DSH serves a smaller contingent of conserved individuals referred by the counties and inmates from the California Department of Corrections and Rehabilitation. DSH is responsible for the daily care and provision of mental health treatment of its patients. Upon discharge from a DSH commitment, individuals typically return to their community, and the county behavioral health system serves to provide additional services and linkages to treatment.

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton). In addition to state hospital treatment, DSH provides services in contracted Jail-Based Competency Treatment (JBCT), Community-Inpatient Facilities (CIF), Conditional Release Program (CONREP), Community-Based Restoration (CBR), and pre-trial felony mental health Diversion programs. DSH is responsible for the daily care of over 7,000 patients. In fiscal year (FY) 2022-23, DSH served over 13,000 patients, with 9,140 served across the state hospitals, 1,912 in JBCT, 207 in CIF, 620 in CBR contracted programs, and 794 in CONREP programs. 11,259 individuals were treated within a DSH inpatient program and 1,875 were served through DSH's outpatient programs. Through Early Access Stabilization Services (EASS) and Re-evaluation services, during FY 2022-23, DSH initiated services for 1,427 patients in EASS, and off ramped 546 through DSH's Re-Evaluation program. In addition, during FY 2022-23, 477 individuals were diverted from jail into county diversion programs funded by DSH.

With nearly 13,000 employees located across its Sacramento headquarters and five state hospitals throughout the state, every team member's effort at DSH focuses on the provision of mental health treatment in a continuum of treatment settings while maintaining the safety of patients, employees, and the public. Approximately half of the Department's employees are in nursing classifications, including psychiatric technicians and registered nurses that provide care for patients in DSH's state hospitals.

DSH is funded through the General Fund and reimbursements from counties for the care of Lanterman-Petris-Short (LPS) patients. All DSH facilities are licensed through the California Department of Public Health (CDPH) and four of the five facilities

(Atascadero, Metropolitan, Napa, and Patton) are accredited by The Joint Commission, an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States.

STATE HOSPITALS

DSH-Atascadero

Opened in 1954, DSH-Atascadero is located on the Central Coast of California in Atascadero (San Luis Obispo County). The hospital is a forensic mental health hospital and is a self-contained psychiatric hospital constructed within a security perimeter. The majority of the all-male patient population is remanded for treatment by county superior courts or by the California Department of Corrections and Rehabilitation (CDCR) pursuant to various sections of the California Penal Code (PC) and the Welfare and Institutions Code (WIC). DSH-Atascadero primarily serves the following four patient commitment types: Offender with a Mental Health Disorder (OMD), *Coleman* patients (inmates with serious mental illness) from CDCR, Incompetent to Stand Trial (IST), and Not Guilty by Reason of Insanity (NGI).

DSH-Coalinga

Opened in 2005, DSH-Coalinga is located on the western edge of Fresno County. DSH-Coalinga is a forensic mental health hospital and primarily treats Sexually Violent Predators (SVP). It is a self-contained psychiatric hospital constructed with a security perimeter. CDCR provides perimeter security as well as transportation of patients to outside medical services and court proceedings. The majority of the all-male patient population is remanded for treatment by county superior courts or CDCR pursuant to various sections of the California PC and the WIC. DSH-Coalinga primarily serves the following three patient commitment types: OMD, *Coleman* patients from CDCR, and Sexually Violent Predators (SVP).

DSH-Metropolitan

Opened in 1916, DSH-Metropolitan is located in Norwalk (Los Angeles County). The hospital is an open style campus within a security perimeter. Due to concerns raised by the community, DSH-Metropolitan maintains a formal agreement with the City of Norwalk and the Los Angeles County Sheriff not to accept patients charged with murder or a sex crime, or at high risk for escape. This agreement has limited the total number of patients that DSH-Metropolitan can treat below the licensed bed capacity. Until 2019, DSH-Metropolitan's operational bed capacity was restricted due to multiple units that were located outside of the hospital's secured treatment area (STA). The units outside of the STA were unable to house forensic patients. To provide additional capacity to serve forensic patients, a secured fence was constructed to surround the housing units located next to the existing secure

treatment area. To provide additional capacity to address an ongoing system-wide forensic waitlist, the Budget Act of 2016 included the capital outlay construction funding for the Increased Secure Bed Capacity project, which was recently completed. DSH-Metropolitan primarily serves the following four patient commitment types: LPS, IST, OMD and NGI.

DSH-Napa

Opened in 1875, DSH-Napa is located in Napa County. Most of the hospital is a forensic mental health hospital and the first State Hospital. DSH-Napa is the oldest California state hospital still in operation and has an open style campus with a security perimeter. DSH-Napa primarily serves the following four patient commitment types: LPS, IST, OMD, and NGI.

DSH-Patton

Opened in 1893, DSH-Patton is located in the town of Highland in San Bernardino County. Most of the hospital is a forensic mental health hospital and has an open style campus with a security perimeter. Due to concerns from the community about the risk of a patient escape, CDCR correctional officers provide perimeter security and transportation at DSH-Patton. DSH-Patton primarily serves the following four patient commitment types: LPS, IST, OMD, and NGI.

For additional information on the specific state hospitals, please reference the DSH Hospital Profiles located within Section F2.

Community Based and Jail-Based Treatment

Since 1986, with the implementation of CONREP, community-based treatment has been part of the program options for forensically committed individuals. In 1996, SVPs were added to the CONREP population, thereby expanding the number of patients served in the community. In response to the *Stiavetti v Clendenin* ruling and significant growth in the IST waitlist, in 2021, DSH convened an IST Solutions Workgroup. Many of the suggestions developed by the IST Solutions Workgroup were included in the IST Solutions budget package in the Budget Act of 2022[1] with an emphasis on community-based treatment options including Felony Mental Health Diversion, Community Based Restoration (CBR) and Community Inpatient Facility (CIF) programs. Further, the IST Solutions Budget Package provided support to implement jail-based treatment through the Early Access Stabilization Services (EASS)program, recognizing the need for treatment intervention at the earliest point possible to support stabilization and increase opportunities for eligibility and placement to Diversion and CBR programs. These new programs, together with foundational IST treatment programs available through the state hospitals and JBCT programs,

[1] See IST Solutions (Section C9) for more information

establish a robust continuum of care for DSH patients. Lastly, the Budget Act of 2022 amended PC Section 1370 to statutorily prioritize community outpatient treatment effective July 1, 2023, increasing consideration for placement of IST patients in Diversion, CBR, or other community IST facilities. DSH continues to focus efforts on the expansion of community-based treatment to reduce the forensic waitlist and to encourage diversified treatment to reverse the cycle of criminalization for individuals with serious mental illness and increase community transitions for state hospital patients.

DEPARTMENT OF STATE HOSPITALS
FUNCTIONAL VACANCY DISPLAY
Informational Only

BACKGROUND

The Department of State Hospitals (DSH) functional vacancy table displays how major functions within the State Hospitals rely on multiple staffing strategies such as overtime, temporary help, and contracted staff to provide critical patient services. While other functions in the hospitals use some level of overtime, temporary help, or contracted staff, the reliance on these staffing alternatives is highest for treatment teams, primary care, nursing services, and protective services. In the tables below, overtime, temporary help, and contracted staff are converted to full-time equivalents (FTEs) to reflect the true vacancy rate for these classifications. This information is unavailable through other budget documents as the Salaries and Wages galley does not provide information on 1) the specific classifications that use overtime, 2) the classifications that are used in temporary help, and 3) contracted staff, as these are reflected in operating expenditures and equipment (OE&E) in the budget. As a result, the Salaries and Wages galley does not provide a true vacancy rate for these classifications. DSH provides an updated functional vacancy table annually as part of the Governor's Budget update.

The pertinent information in this table can be found in the following columns:

- Departmental Regular/Ongoing Authorized Positions ties to the 4440-fiscal year (FY) 2023-24 Schedule 7A, FY 2022-23 Authorized Positions
- Temporary Help includes employees working second positions, retired annuitants, limited term, and permanent intermittent
- Total Authorized Positions contains the total Regular/Ongoing Authorized Positions and Temporary Help positions for specific classifications
- Contracted FTE and Overtime FTE contain FTE positions which have been converted from contract hours and overtime hours
- Total Filled FTE is the grand total of Total Filled Civil Service Positions, Temp Help Filled, Contracted FTE, and Overtime FTE
- Functional Vacancy FTE is the calculated difference between Total Filled Civil Service Positions and Total Filled FTE
- Functional Vacancy Rate is calculated by dividing Functional Vacancy FTE by Total Authorized Positions

Examining the results of this data allows the following observations about how the hospitals fulfill the need for critical patient services:

- Clinical Services – Treatment Team and Primary Care: For the Staff Psychiatrist positions, state hospitals utilized temporary help and contract employees to staff 22.4% of the filled positions. These positions are a hard-to-fill classification at State Hospitals, due in part to the nationwide shortage of psychiatrists. DSH has been authorized to establish psychiatry residency programs at DSH-Napa in partnership with St. Joseph's Medical Center and at DSH-Patton to assist with training more psychiatrists to work in the DSH system. The first cohort at DSH-Napa started in July 2021 and is currently on its third cohort totaling 20 residents and DSH-Patton has recently been authorized to begin developing its own residency program. Additionally, DSH has been authorized to expand or develop fellowship programs across the state hospitals, as well.

- Clinical Services – Nursing: The high utilization rates for temporary help and overtime reflect a finding from the Clinical Staffing Study for 24-Hour Care Nursing Services, which determined that the state hospitals do not have enough authorized nursing positions to fill all the posts on the units. This finding was discussed in the Direct Care Nursing Budget Change Proposal (BCP) included in the Budget Act of 2019. This BCP provided resources to help close the gap but assumed some temporary help and overtime will continue to be utilized to meet the patient care needs. DSH continues to work to fill the resources authorized by this BCP. Additionally, overtime hours associated with these classifications have increased as a result of the COVID-19 pandemic.

- Protective Services: As discussed in the Protective Services BCP included in the Budget Act of 2020, DSH-Napa does not have sufficient position authority to cover the protective services posts necessary to fulfill essential police functions which is a driver for overtime for protective services classifications. While new positions were authorized by this BCP to provide additional protective services resources, these positions were phased in over several years and are still undergoing recruitment and hiring.

Department of State Hospitals	Hospital Position Report Average of FY 2022-23									
Classifications	Departmental Regular/ Ongoing Authorized Positions[1]	Temp Help	Total Authorized Positions	Total Filled Civil Service Positions[2]	Temp Help Filled	Contracted FTE	Overtime FTE[3]	Total Filled FTE	Functional Vacancy FTE[4]	Functional Vacancy Rate
Clinical Services - Treatment Team and Primary Care										
Social Worker (9872, 9874)[5]	293.6	0.0	293.6	216.8	3.2	0.0	0.0	220.0	73.6	25.1%
Rehab Therapist - Safety (8321, 8323, 8324, 8420, 8422)	298.5	0.0	298.5	237.8	1.4	0.0	4.0	243.2	55.3	18.5%
Psychologist-Clinical-Safety (9873)	242.7	0.0	242.7	169.9	4.9	8.2	0.0	183.0	59.7	24.6%
Staff Psychiatrist-Safety (7619)	271.5	0.0	271.5	126.3	4.0	56.7	0.0	187.0	45.2	31.1%
Nurse Practitioner-Safety (9700)	39.0	0.0	39.0	34.1	1.4	0.0	0.2	35.7	3.9	9.9%
Physician & Surgeon-Safety (7552)[6]	124.5	0.0	124.5	96.9	2.4	7.7	0.0	107.0	17.6	14.1%
Total: Clinical Services - Treatment Team and Primary Care	**1,269.8**	**0.0**	**1,269.8**	**881.9**	**17.3**	**72.6**	**4.2**	**976.0**	**294.5**	**23.2%**
Clinical Services - Nursing										
Psychiatric Technician (8236, 8253, 8254, 8274)	3,691.2	137.6	3,828.8	2,767.2	197.8	48.2	720.5	3,733.7	278.1	7.3%
Registered Nurse-Safety (8094)	1,592.7	115.2	1,707.9	1,321.9	83.8	81.9	227.6	1,715.2	39.4	2.3%
Senior Psych Tech-Safety (8252) [7]	344.9	1.3	346.2	361.3	5.1	0.0	132.8	499.2	0.0	0.0%

Total: Clinical Services - Nursing	**5,628.8**	**254.1**	**5,882.8**	**4,450.4**	**286.7**	**130.1**	**1,080.9**	**5,948.1**	**317.5**	**5.4%**
Protective Services										
Hosp Police Lieut (1935)	29.4	0.0	29.4	20.7	1.3	0.0	5.3	27.3	4.3	14.7%
Hosp Police Sgt (1936)	99.2	0.0	99.2	81.2	2.0	0.0	18.8	102.0	5.8	5.9%
Hosp Police Ofcr (1937)	726.8	0.0	726.8	558.8	17.5	0.0	137.1	713.4	27.9	3.8%
Total: Protective Services	**855.4**	**0.0**	**855.4**	**660.6**	**20.8**	**0.0**	**161.2**	**842.6**	**38.1**	**4.5%**

[1] Total includes Administratively Established positions
[2] Total includes Administratively Established positions
[3] Overtime data per month is "point in time" and monthly updates to this data set may affect previous months' totals.
[4] Functional Vacancy FTE is calculated individually per hospital, then summarized to display a final total.
[5] Includes 16.0 positions established via MBR: Treatment Team.
[6] Includes 25.9 positions established via MBR: Treatment Team.
[7] The Senior Psych Tech-Safety classification is interchangeable with the Psychiatric Technician classification on the 7A, which is a point in time document, and any vacant positions are shown as Psychiatric Technicians on the 7A itself. Filled amount is an average throughout the 12 months of FY 2022-23.

DEPARTMENT OF STATE HOSPITALS POPULATION

	2023-24 May Revision Projection	CURRENT YEAR 2023-24					
	June 30, 2023 Projected Census	July 1, 2023 Actual Census	Previously Approved Adjustments CY 2023-24	2024-25 November Adjustment CY 2023-24	Mid Year Census Adjustment	2024-25 May Revision Adjustment CY 2023-24	June 30, 2024 Projected Census
POPULATION BY HOSPITAL							
ATASCADERO	1,052	1,067	0	0	0	0	1,067
COALINGA	1,321	1,341	0	0	0	0	1,341
METROPOLITAN	790	762	140	0	0	0	902
NAPA	1,107	1,103	0	0	0	0	1,103
PATTON	1,304	1,416	10	0	0	0	1,426
TOTAL BY HOSPITAL	**5,574**	**5,689**	**150**	**0**	**0**	**0**	**5,839**
POPULATION BY COMMITMENT							
Coleman - PC 2684[1]	88	112	0	0	0	0	112
IST - PC 1370	1,682	1,768	144	0	0	0	1,912
LPS & PC 2974	594	585	0	0	0	0	585
NGI - PC 1026	1,219	1,225	0	0	0	0	1,225
OMD - PC 2962	345	334	3	0	0	0	337
OMD - PC 2972	693	711	3	0	0	0	714
SVP - WIC 6602/6604	953	954	0	0	0	0	954
TOTAL BY COMMITMENT	**5,574**	**5,689**	**150**	**0**	**0**	**0**	**5,839**
CONTRACTED PROGRAMS							
TREATMENT	422	362	160	0	0	0	522
COMMUNITY BASED RESTORATION	750	648	300	0	0	0	948
COMMUNITY INPATIENT FACILITIES	78	70	113	0	0	0	183
TOTAL-CONTRACTED PROGRAMS	**1,250**	**1,080**	**573**	**0**	**0**	**0**	**1,653**
CONREP PROGRAMS[2]							
CONREP SVP	27	20	7	0	0	0	27
CONREP NON-SVP	657	614	60	0	0	0	674
CONREP FACT PROGRAM	180	56	124	-90	0	0	90
CONREP STEP DOWN FACILITIES	185	43	141	0	0	0	184
TOTAL - CONREP PROGRAMS	**1,049**	**733**	**332**	**-90**	**0**	**0**	**975**
CY POPULATION AND CONTRACTED TOTAL	**7,873**	**7,502**	**1,055**	**-90**	**0**	**0**	**8,467**

Total IST Population (excluding CONREP)

July 1, 2023 Actual:	2,848
June 30, 2024 Projected:	3,565

DEPARTMENT OF STATE HOSPITALS POPULATION

	2024-25 May Revision Projection	BUDGET YEAR 2024-25				
	June 30, 2024 Projected Census	**July 1, 2024 Projected Census**	**Previously Approved Adjustments BY 2024-25**	**2024-25 November Adjustment BY 2024-25**	**2024-25 May Revision Adjustment BY 2024-25**	**June 30, 2025 Projected Census**
POPULATION BY HOSPITAL						
ATASCADERO	1,052	1,067	0	0	0	1,067
COALINGA	1,321	1,341	0	0	0	1,341
METROPOLITAN	930	902	0	0	0	902
NAPA	1,107	1,103	0	0	0	1,103
PATTON	1,314	1,426	0	0	0	1,426
TOTAL BY HOSPITAL	**5,724**	**5,839**	**0**	**0**	**0**	**5,839**
POPULATION BY COMMITMENT						
Coleman - PC 2684[1]	88	112	0	0	0	112
IST - PC 1370	1,826	1,912	0	0	0	1,912
LPS & PC 2974	594	585	0	0	0	585
NGI - PC 1026	1,219	1,225	0	0	0	1,225
OMD - PC 2962	348	337	0	0	0	337
OMD - PC 2972	696	714	0	0	0	714
SVP - WIC 6602/6604	953	954	0	0	0	954
TOTAL BY COMMITMENT	**5,724**	**5,839**	**0**	**0**	**0**	**5,839**
CONTRACTED PROGRAMS						
TREATMENT	541	522	27	18	0	567
COMMUNITY BASED RESTORATION	1,931	948	758	0	0	1,706
COMMUNITY INPATIENT FACILITIES	118	183	40	0	0	223
TOTAL-CONTRACTED PROGRAMS	**2,590**	**1,653**	**825**	**18**	**0**	**2,496**
CONREP PROGRAMS[2]						
CONREP SVP	27	27	4	0	0	31
CONREP NON-SVP	673	674	0	0	0	674
CONREP FACT PROGRAM	180	90	0	0	0	90
CONREP STEP DOWN FACILITIES	185	184	0	0	0	184
TOTAL - CONREP PROGRAMS	**1,065**	**975**	**4**	**0**	**0**	**979**
BY POPULATION AND CONTRACTED TOTAL	**9,379**	**8,467**	**829**	**18**	**0**	**9,314**

Total IST Population (excluding CONREP)

July 1, 2024 Projected: 3,565
June 30, 2025 Projected: 4,408

POPULATION DATA
STATE HOSPITALS
POPULATION AND PERSONAL SERVICES ADJUSTMENTS
Informational Only

BACKGROUND

A change in position and expenditure authority in fiscal year (FY) 2023-24 and FY 2024-25 is based on a broad range of factors and variables specific to the delivery of patient treatment. These variables may include treatment categories, patient legal classifications, capacity and facility adjustments impacting safety and security. Changes amongst these variables drive clinical and non-clinical staffing needs within state hospitals to meet staff-to-patient ratios, clinical caseloads, and other staffing methodologies adopted in the Budget Acts of 2019 and 2020.

To address treatment, population and facility changes, and the subsequent impact to hospital staffing, the Department of State Hospitals (DSH) conducts biannual assessments including census and population projections to identify significant fluctuations in hospital bed capacity and population growth as seen in the pending placement list, and adjustments within treatment categories, facilities, and treatment capacity.

POPULATION PROJECTIONS

Census and Pending Placement List Projections

DSH utilizes the July 1, 2023, actual census as the baseline census for both FY 2023-24 and FY 2024-25. For the 2024-25 Governor's Budget and May Revision, the methodologies to project future census figures are applied as described below.

Methodology[1]

In the 2016-17 Governor's Budget, DSH implemented a methodology to project the pending placement list, which has since been enhanced and expanded to include additional commitments through collaborative efforts with the University of California, Irvine's (UCI) Department of Criminology, Law, and Society research team. DSH continues to use this as the standard forecasting tool to project the pending placement list for the Incompetent to Stand Trial (IST), Lanterman–Petris–Short (LPS), Offender with a Mental Health Disorder (OMD), Not Guilty by Reason of Insanity (NGI), and Sexually Violent Predator (SVP) populations.

[1] This methodology does not project for the *Coleman* patients. The Department of Corrections and Rehabilitation (CDCR) determines the bed need and produces projections for the *Coleman* population.

This methodology utilizes four primary measures, as well as expected systemwide capacity expansions[2], to forecast the pending placement list. These measures include pending admissions, average referrals, average admissions, and average length of stay (ALOS). A projected pending placement list is generated by adding a point-in-time pending placement list value to an average of monthly new patient referrals. This value is then reduced by the correlating average of monthly admissions, which are offset to incorporate any bed decreases. Expected systemwide capacity increases, augmented by the appropriate ALOS, are then subtracted from the projected pending placement list to yield a modified pending placement list projection for future months.

The projected pending placement list for FY 2023-24 and FY 2024-25 is based on the modified pending placement list value calculated for June 30, 2024, and June 30, 2025. Variables are specific to patient legal class and are calculated based on trends observed in the 12-month period ending August 31, 2023.

Table 1 below provides the DSH pending placement list projections for the IST, LPS, OMD, NGI and SVP populations. The table also presents the actual census for July 1, 2023, as well as the projected census for FY 2023-24 and FY 2024-25 for all DSH populations. The projected census for June 30, 2024 (for FY 2023-24) and June 30, 2025 (for FY 2024-25) reflects the actual census as well as the approved and proposed census adjustments.

[2] Systemwide capacity expansions include state hospitals, jail-based competency treatment programs, community inpatient facility programs, and community-based restoration programs.

Table 1: Census and Pending Placement List Projections

CURRENT YEAR			
Legal Class	**July 1, 2023 Actual Census**	**June 30, 2024 Projected Census**	**June 30, 2024 Projected Pending Placement List**
IST	2,848	3,565	447
LPS	585	585	416
NGI	1,225	1,225	0
OMD2962	334	337	32
OMD2972	711	714	0
SVP	954	954	0
Coleman[1]	*112*	*112*	*N/A*
Subtotal	*6,769*	*7,492*	*895*
CONREP[2]	733	975	N/A
Total	**7,502**	**8,467**	**895**
BUDGET YEAR			
Legal Class	**July 1, 2024 Projected Census**	**June 30, 2025 Projected Census**	**June 30, 2025 Projected Pending Placement List**
IST	3,565	4,408	368
LPS	585	585	525
NGI	1,225	1,225	0
OMD2962	337	337	32
OMD2972	714	714	0
SVP	954	954	0
Coleman[1]	112	112	N/A
Subtotal	7,492	8,335	925
CONREP[2]	975	979	N/A
Total	**8,467**	**9,314**	**925**

[1] The projected pending place list is not calculated for the Coleman population within the DSH forecasting model. Projections for the Coleman population is developed by CDCR.
[2] The projected census for CONREP is based on the contracted caseload. Actual census may vary based on activation delays.

Referral and Census Trends

Over the span of the last six years, DSH has seen an increase of almost 45% in IST referrals when comparing annual referral rates from FY 2017-18 through FY 2022-23. Notably, during FY 2019-20 and FY 2020-21, DSH observed declines in IST referrals, which were attributed to the COVID-19 pandemic and disruption of court proceedings. However, county courts have since resumed their activities, subsequently leading to surges in IST referral rates that show a consistent year over year increase. In FY 2022-23, DSH experienced another unprecedented growth in referrals, with an increase of 18% in IST referrals as compared to the preceding year. The data displayed in Table 2 below highlights a significant and sustained trend in IST referral growth.

Table 2: Average Monthly Referrals*

	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	% Change
IST	339	383	343	346	415	488	18%
LPS	18	16	<11	12	<11	***	19%
NGI	18	11	<11	<11	<11	***	-3%
OMD 2962	49	46	43	26	27	30	10%
OMD 2972	<11	<11	<11	<11	<11	<11	-17%
SVP	<11	<11	<11	<11	<11	<11	-20%
Coleman	46	35	46	16	16	17	4%
	485	**498**	**456**	**416**	**483**	**559**	**16%**

*Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Following the onset of COVID-19, DSH experienced a reduction in its patient census. As DSH began its post-pandemic recovery, there was a substantial increase in admissions, leading to an increase in state hospital census. Along with increased hospital admission rates, DSH has been rapidly implementing an array of innovative IST solutions to address the increasing IST referrals and pending placement list. These include expansion of community-based treatment and diversion options for felony ISTs, activation of community inpatient facility programs, expansion of existing Jail Based Community Treatment (JBCT) programs, and the addition of new JBCT programs to serve the IST population. All these efforts have resulted in an increase of 36% in IST census between June 2022 and June 2023.

Table 3: Patient Census

	6/30/2019	6/30/2020	6/30/2021	6/30/2022	6/30/2023	% Change
IST*	1,929	2,108	1,951	2,096	2,843	36%
LPS	736	747	789	707	584	-17%
NGI	1,416	1,415	1,338	1,244	1,225	-2%
OMD 2962	559	508	415	383	334	-13%
OMD 2972	778	760	716	685	710	4%
SVP	962	943	939	956	954	0%
Coleman	185	296	169	114	112	-2%
Subtotal	**6,565**	**6,777**	**6,317**	**6,185**	**6,762**	**9%**
CONREP	646	661	647	714	733	3%
Total	**7,211**	**7,438**	**6,964**	**6,899**	**7,495**	**9%**

* IST census includes the following facilities and programs: state hospitals, community-based restoration program, IST diversion, jail-based competency treatment program, and community inpatient facilities.

Post COVID-19 Impact

Throughout the pandemic, DSH followed the guidance issued by the Centers for Disease Control and Prevention (CDC), California Public Health (CDPH), epidemiologists and medical Subject Matter Experts (SMEs), and by the local county public health director for each DSH facility. As COVID-19 guidance has changed and eased requirements for health care entities from earlier phases of the pandemic, the impacts to DSH operations and census lessened. While DSH continues to take the necessary steps to mitigate the spread of infection, such as exposure testing and isolation of COVID-19 positive patients; some interventions such as Admission Observation Units (AOUs), for patients entering state hospitals, are no longer required. As a result, DSH has been able to increase admissions, leading to an increase of census and a decrease in the pending placement list. DSH reached a high of 1,953 IST patients on the pending placement list as of January 2022 and is now down to 549 as of November 6, 2023. This significant reduction is due to rapid implementation of the IST solutions authorized in the budget, easing of CDC and CDPH requirements on healthcare facilities in response to the pandemic, no longer having to cohort admissions, and shorter quarantine timelines associated with exposures.

STAFFING ANNUAL ASSESSMENT

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was assembled to perform a thorough analysis of past practices and staffing methodologies, and ensure they continue to be adequate and appropriate for the department's growing and evolving populations across all DSH facilities. The standardized staffing methodologies, supported through the Department of Finance (DOF) Mission-Based Review (MBR) and adopted in the Budget Acts of 2019 and 2020, provide data driven and data informed methods to calculate hospital staffing across the following areas:

- Hospital Forensic Departments
- 24-Hour Care Nursing Services
- Treatment Planning and Delivery
- Protective Services

These four components each provide critical and required services to DSH patients through statutorily required forensic evaluations for the courts, 24-hour housing and nursing care, delivery of psychiatric and medical treatment, and safety and security to patients and staff.

Staffing Adjustments

Using the methodologies and unit categorization system established in the staffing studies, DSH will examine fluctuations to treatment categories, population and facilities and identify necessary staffing adjustments that impact position and expenditure authority.

<u>FY 2023-24</u>

DSH is not currently requesting a change in position and expenditure authority in accordance with the standard staffing and funding methodology outlined above.

<u>FY 2024-25</u>

DSH-Coalinga

DSH must regularly assess the level of care needs for its patient population, specifically as it relates to DSH-Coalinga's aging patient population. In FY 2022-23, DSH Coalinga converted an SVP Residential Recovery Unit (RRU) to an SVP intermediate care facility (ICF) level of care unit to begin addressing this need. The 2024-25 Governor's Budget Estimate item, DSH-Coalinga Intermediate Care Facility Conversion, addresses this continued need to support the patient population.

DSH-Metropolitan

Changes to DSH-Metropolitan's population and treatment categories may necessitate a staffing assessment based on DSH's staffing standards. This assessment will apply described staffing methodologies across DSH-Metropolitan's population and treatment units to determine if these changes impact position authority and expenditure resources. The primary factors requiring this assessment include the following changes at DSH-Metropolitan:

- Increase in total capacity unaccounted for in the Hospital Forensic Services Department staffing standard implementation due to the timing of implementation and the subsequent increase in capacity associated with expansion of the secure treatment area.
- The high workload associated with the increased capacity anticipated to treat IST designated patients.
- Changes in treatment categories, including:
    - Conversion of moderate workload longer-term forensic legal classifications (NGI and OMD) units to higher workload legal classifications (IST) units.
    - Shift in legal classifications, reflecting an increased treatment focus for IST patients and decreased capacity across other legal classifications, such as LPS.

DSH-Atascadero

Changes to DSH-Atascadero's population and treatment categories may necessitate a staffing assessment based on DSH's staffing standards. This assessment will apply described staffing methodologies across DSH-Atascadero's population and treatment units to determine if these changes impact position authority and expenditure resources. The primary factors requiring this assessment include the following changes at DSH-Atascadero:

- Changes in treatment categories, including shift in legal classifications, reflecting an increased treatment focus for IST patients and decreased capacity across other legal classifications, such as OMD PC2962.
- Changes in workload associated with the changes in legal classifications unaccounted for in the staffing study staffing standards due to timing.

Findings from this assessment impacting position and expenditure authority may be presented in the 2024-25 May Revision.

DSH Staffing Standards
Unit-Based Nursing, Treatment Team, and Primary Care Staffing

Treatment Category & Unit Type Sub-Category	Nursing			Treatment Team		Primary Care	
	AM Shift Ratios	PM Shift Ratios	NOC Shift Ratios	Workload Designation	Caseload Ratios	Workload Designation	Caseload Ratios
Admissions							
PC Standard Admissions	1: 4.5	1: 5	1: 8	High	1:15	Standard	1:45
Hybrid Admissions	1: 5.5	1: 5.5	1: 9.5	High	1:15	Standard	1:45
Medical Treatment							
Medical Unit	1: 2	1: 2	1: 2.5	Moderate	1:30	High	1:15
Skilled Nursing Facility	1: 2.5	1: 2.5	1: 4	Moderate	1:30	High	1:15
Medically Fragile/Geropsych	1: 4.5	1: 5	1: 7.5	Moderate	1:30	Moderate	1:30
Specialized Services Treatment							
High Aggression/Enhanced Treatment Unit (ETU)	1: 1.5	1: 1.5	1: 3	High	1:15	Standard	1:45
Enhanced Treatment Program (ETP)	1: 1.5	1: 1.5	1: 3	High	1:13*	Standard	1:45
PC Specialized Services: Intermediate Care High Behavior Acuity	1: 4.5	1: 4.5	1: 7.5	High	1:15	Standard	1:45
PC Specialized Services: Polydipsia	1: 5.5	1: 5.5	1: 9	High	1:15	Standard	1:45
PC Specialized Services: DBT	1: 5.5	1: 5.5	1: 9	High	1:15	Standard	1:45
LPS Specialized Services: Polydipsia	1: 3	1: 3	1: 4.5	High	1:15	Standard	1:45
LPS Specialized Services: DBT	1: 3	1: 3	1: 4.5	High	1:15	Standard	1:45
LPS Specialized Services: Acute Psychiatric/Pre-DBT	1: 3	1: 3	1: 4.5	High	1:15	Standard	1:45
Specialized Services: Deaf, Hard of Hearing	1: 3	1: 3	1: 6	High	1:15	Standard	1:45
PC Specialized Services: Substance Abuse	1: 5.5	1: 5.5	1: 9	Moderate	1:30	Standard	1:45
PC Specialized Services: Psychologically Fragile	1: 5.5	1: 5.5	1: 9	Moderate	1:30	Standard	1:45
Specialized Services: Sex Offender Treatment	1: 7.5	1: 7.5	1: 14	Moderate	1:30	Standard	1:45
Specialized Services: Monolingual	1: 5	1: 5.5	1: 8	Moderate	1:30	Standard	1:45

Incompetent to Stand Trial (IST) Treatment							
IST Admission to Discharge	1:5.5	1:5.5	1:9.5	High	1:15	Standard	1:45
IST Permanent Housing-Single Rooms	1:5.5	1:6.5	1:9.5	Moderate	1:30	Standard	1:45
IST Permanent Housing-Dorm, Mixed Rooms	1:6.5	1:6.5	1:12	Moderate	1:30	Standard	1:45
Offender with a Mental Disorder (OMD) Treatment							
OMD Permanent Housing-Single, Mixed Rooms	1:5	1:5	1:10	Moderate	1:30	Standard	1:45
Multi-Commitment Treatment							
OMD, NGI, LPS Permanent Housing-Dorm, Mixed Rooms	1:6.5	1:6.5	1:12	Moderate	1:30	Standard	1:45
OMD, NGI Permanent Housing-Single Rooms	1:5.5	1:6.5	1:11	Moderate	1:30	Standard	1:45
CDCR/OMD Permanent Housing	1:7.5	1:8	1:13	Moderate	1:30	Standard	1:45
CDCR (Coleman) Treatment							
CDCR Permanent Housing	1:5.5	1:6	1:12	Moderate	1:30	Standard	1:45
Sexually Violent Predator (SVP) Treatment							
SVP Permanent Housing	1:6	1:6.5	1:14	Moderate	1:30	Standard	1:45
SVP Residential Recovery Unit	1:13	1:17	1:33	Low	1:50	Standard	1:45
Lanterman-Petris Short (LPS) Treatment							
LPS Permanent Housing	1:5	1:5	1:9	High	1:15	Standard	1:45
Discharge Preparation Units							
Discharge Ready	1:7	1:7.5	1:13	Low	1:35	Standard	1:45

* ETP units are designated as a high treatment team workload units but staffing is set in statute at one team per unit that consists of one psychiatrist, two psychologists, one clinical social worker, and two rehabilitation therapists.

STATE HOSPITALS AND PSYCHIATRIC PROGRAMS
COMMITMENT CODES

Legal Category	Legal Class Text	Code Section	Description
NGI	NGI PC1026	PC 1026	Not Guilty by Reason of Insanity
Other NGI*	RONGI, RO1026	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason of Insanity
IST	IST PC1370	PC 1370 or TITLE 18 USC 4244	Incompetent to Stand Trial
Other IST	MIST	PC 1370.01	Misdemeanant Incompetent to Stand Trial
Other IST	EIST	PC 1372(e)	Restored (IST) on Court Hold
Other IST	ROIST, RO1370	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1370 (IST)
Other IST*	DDIST	PC 1370.1	Commitment as Incompetent to Stand Trial because of Developmental Disability (up to 6 months) and Mental Disorder
OMD	PC2962	PC 2962	Parolee Referred from the Department of Corrections
OMD	PC2964a	PC 2964(a)	Parolee Rehospitalized from CONREP after DSH hearing
OMD	PC2972	PC 2972	Former Parolee Referred from Superior Court
OMD*	RO2972	PC 1610	Temporary admission while waiting for court revocation of PC 2972
MDSO*	MDSO	WIC 6316	Mentally Disordered Sex Offender--Observation
MDSO*	MDSOI	WIC 6316	1. MDSO Observation Indeterminate; 2. MDSO Return by Court
MDSO*	ROMDSO	PC 1610	Temporary Admission while waiting for Court Revocation of MDSO
Other SVP	SVPH	WIC 6601.3	Sexually Violent Predator Board of Parole Hearings (BPH) Hold
Other SVP	SVPE	WIC 6600	Sexually Violent Predator Court Hold
SVP	SVP	WIC 6604	Sexually Violent Predator
SVP	SVPP	WIC 6602	Sexually Violent Predator Probable Cause
PC 2684	PC2684	PC 2684	Prisoner from the Department of Corrections
PC 2685	PC2684A	PC 2684A	Prisoner from the Department of Corrections
DJJ W&I 1756	YAC	WIC 1756	Youth Authority Certification/Youth Authority Referral through Regional Office
LPS	T.Cons	WIC 5353	Temporary Conservatorship
LPS	CONS	WIC 5358	Conservatorship

LPS	VOL	WIC 6000	Voluntary
LPS	DET	WIC 5150	72-Hour Detention
LPS	CERT	WIC 5250	14-Day Certification
LPS	SUIC	WIC 5260	Additional 14-Day Certification for Suicidal Persons
LPS	POST	WIC 5304(a)	180-Day Post Certification--ONLY (until 6/91 used for pending cases also, see 37)
LPS	ADD	WIC 5304(b)	Additional 180-Day Post Certification
LPS	A-CERT	WIC 5270.15	30-Day Certification
LPS	PCD	WIC 5303	Pending Court Decision on 180-Day Post Certification
LPS	MURCON	WIC 5008(h)(1)(B)	Murphy's Conservatorship
LPS	DMR	WIC 6500, 6509	Dangerous Person with Developmental Disability Committed by Court
LPS	CAMR	WIC 4825, 6000(a)	Voluntary Person with Developmental Disability Under Own Signature by Regional Center
LPS	VJCW	WIC 6552	Voluntary Juvenile Court Ward
LPS	DMRH	WIC 6506	Hold Pending Hearing on W&I 6509 Petition
LPS*	PC 2974	PC 2974	Recommitment after expiration of prison term (must have concurrent W&I commitment)

***** Items marked with an asterisk were previously captured in the "Other PC" category

Demographic Snapshot: All Commitment Types

Patients Served from July 1, 2022 to June 30, 2023 is 13,134

Basic Demographics

Sex at Birth

M 83.1%
F 16.9%

Age on June 30, 2022

15,000
10,000
5,000
0
65+ 10.7%
18-64 89.3%

Race

White 35.7%
Hispanic or Latino 29.9%
Black or African American 26.3%
Asian 2.6%
American Indian or Alaska Native Native 0.8%
Hawaiian or Other Pacific Islander 1.8%
Unknown 2.9%

Resident County

5,000
4,000
3,000
2,000
1,000
0
Bay Area 12.9%
Central Region 10.2%
Inland Deserts... 6.3%
North Central... 8.2%
Northern Region 2.0%
South Coast... 36.2%
Unknown 24.3%

Language Spoken at Home

8,000
6,000
4,000
2,000
0
English 40.8%
Other / Unknown 55.9%
Spanish 3.1%
Tagalog <1%
Vietnamese <1%

Program

SH 69.6%
JBCT 14.6%
CIF 1.6%
CONREP 6.0%
LA CBR 4.7%
LA DIV 3.5%

Prevalence of Diagnoses

4,000
3,000
2,000
1,000
0
Bipolar Disorder 4.4%
Other Disorders 7.8%
Paraphilias 6.2%
Schizoaffective disorders 14.7%
Schizophrenia 26.3%
Unspecified psychosis not due to a... 15.7%
Unknown 24.9%

Summary

The data shown above is a combination of State Hospital (SH), Jail-Based Competency Treatment (JBCT), Conditional Release Program (CONREP), Community Inpatient Facility (CIF), LA Community Based Resoration (LA CBR), and LA Diversion (LA DIV) information. The DSH population is composed of 83% males and 17% females; a majority of this population is between the ages of 18 and 64. The age of all patients is calculated as of June 30, 2023. Approximately 36% identify as White, 26% Black, and 30% Hispanic with mostly English spoken at home. The majority of the DSH population are residents of South Coast and Bay Area counties. During this time period, approximately 70% of DSH patients were treated at a State Hospital (excluding transfers from other Programs) and 15% at a JBCT facility. Schizophrenia, Schizoaffective, and Bipolar-type disorders are the three most common diagnoses for the DSH population, accounting for approximately 61% of the population with known diagnoses.

DIVISION OF HOSPITAL STRATEGIC PLANNING AND IMPLEMENTATION
RESEARCH, EVALUATION AND DATA

Patients Served by Race
Fiscal Year 2022-2023

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total
DSH Inpatient and Outpatient Program's Patients Served by Count[1]	*White*	114	2,303	245	849	570	607	4,688
	Hispanic or Latino	98	2,566	231	424	457	147	3,923
	Black or African American	76	2,129	190	366	457	236	3,454
	Asian	<11	199	36	61	28	<11	338
	Unknown	<11	257	***	40	40	***	383
	Native Hawaiian or Other Pacific Islander	<11	106	***	75	29	<11	232
	American Indian or Alaska Native	<11	64	-	12	16	***	111
	TOTAL	313	7,624	736	1,827	1,597	1,032	**13,129**

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total	2021 State of California[2]	2022 State of California[3]
DSH Inpatient and Outpatient Program's Patients Served by Percentage[1]	*White*	36.4%	30.2%	33.3%	46.5%	35.7%	58.8%	35.7%	35.8%	33.7%
	Hispanic or Latino	31.3%	33.7%	31.4%	23.2%	28.6%	14.2%	29.9%	39.5%	40.3%
	Black or African American	24.3%	27.9%	25.8%	20.0%	28.6%	22.9%	26.3%	5.4%	5.2%
	Asian	***%	2.6%	4.9%	3.3%	1.8%	***%	2.6%	14.7%	15.3%
	Unknown	***%	3.4%	***%	2.2%	2.5%	***%	2.9%	0.4%	0.6%
	Native Hawaiian or Other Pacific Islander	***%	1.4%	***%	4.1%	1.8%	***%	1.8%	0.3%	0.3%
	American Indian or Alaska Native	***%	0.8%	0.0%	0.7%	1.0%	***%	0.8%	0.3%	0.3%
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**		

[1] Total counts of Patients Served do not include patient transfers from other facilites.

[2]Taken from U.S. Census Bureau 2021 American Community Survey (ACS 5-Year Estimates). Does not include 3.6% labeled "two or more races".

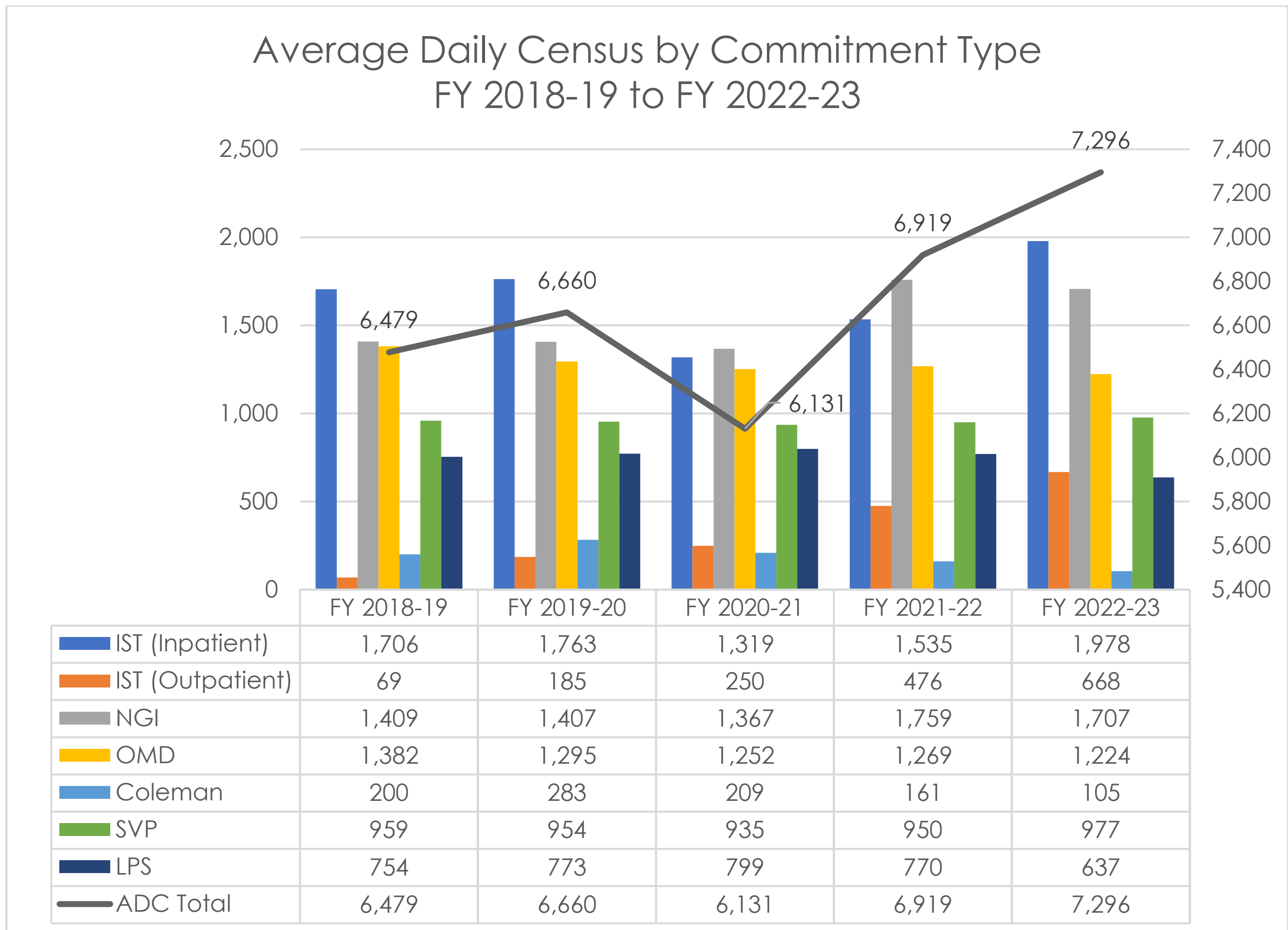
[3]Taken from U.S. Census Bureau 2022 American Community Survey (ACS 1-Year Estimates). Does not include 4.3% labeled "two or more races".

[4]Includes MDSO.

[5]Division of Juvenile Justice patients are excluded and account for less than 11 total patients served (20% White, 20% Hispanic or Latino, 40% Black or African American and 20% Native Hawaiian or Other Pacific Islander). Effective July 1, 2023, DSH no longer serves individuals from the Division of Juvenile Justice.

*Headers represent the following commitments: California Department of Correction and Rehabilitation (CDCR), Incompetent to Stand Trial (IST), Lanterman-Petris Short (LPS), Not Guilty by Reason of Insanity (NGI), Offenders with a Mental Health Disorder (OMD), and Sexually Violent Predator (SVP).

Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or “less than 11” within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.



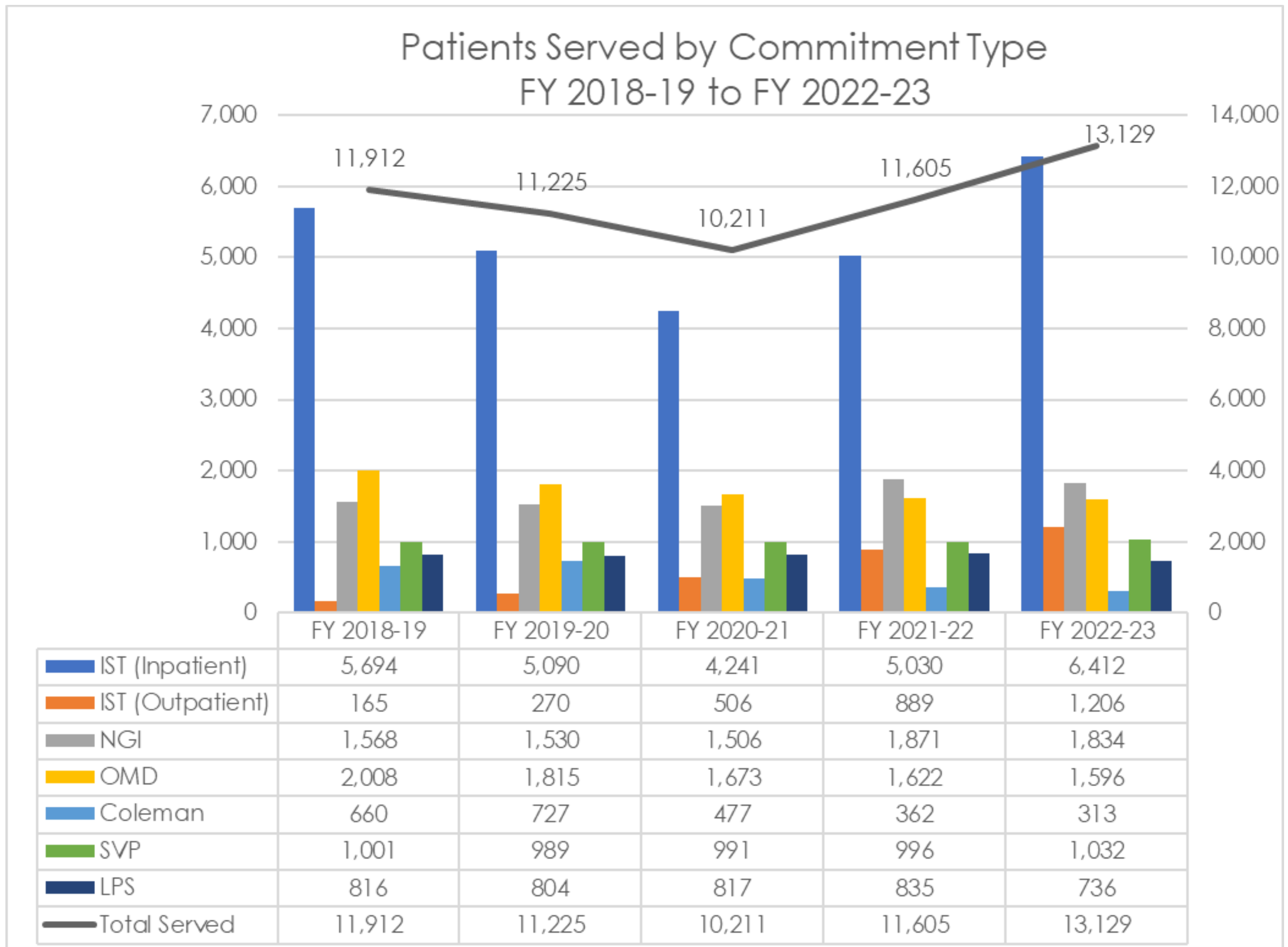
	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
IST (Inpatient)	1,706	1,763	1,319	1,535	1,978
IST (Outpatient)	69	185	250	476	668
NGI	1,409	1,407	1,367	1,759	1,707
OMD	1,382	1,295	1,252	1,269	1,224
Coleman	200	283	209	161	105
SVP	959	954	935	950	977
LPS	754	773	799	770	637
ADC Total	6,479	6,660	6,131	6,919	7,296

Data includes State Hospitals data in all years and for all committments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT) Community. IST Outpatient includes Community Based Restoration all years. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP- Forensic Assertive Community Treatment Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22. Data excludes less than 11 Division of Juvenile Justice (DJJ) Patients in FY 2018-19 through FY 2022-23.

During fiscal year (FY) 2022-23, following the cessation of various COVID-19 pandemic protocols and a return to normal admissions, the Department of State Hospitals (DSH) had an average daily census of 7,298 patients; a 16% growth in average daily census over FY 2021-22.

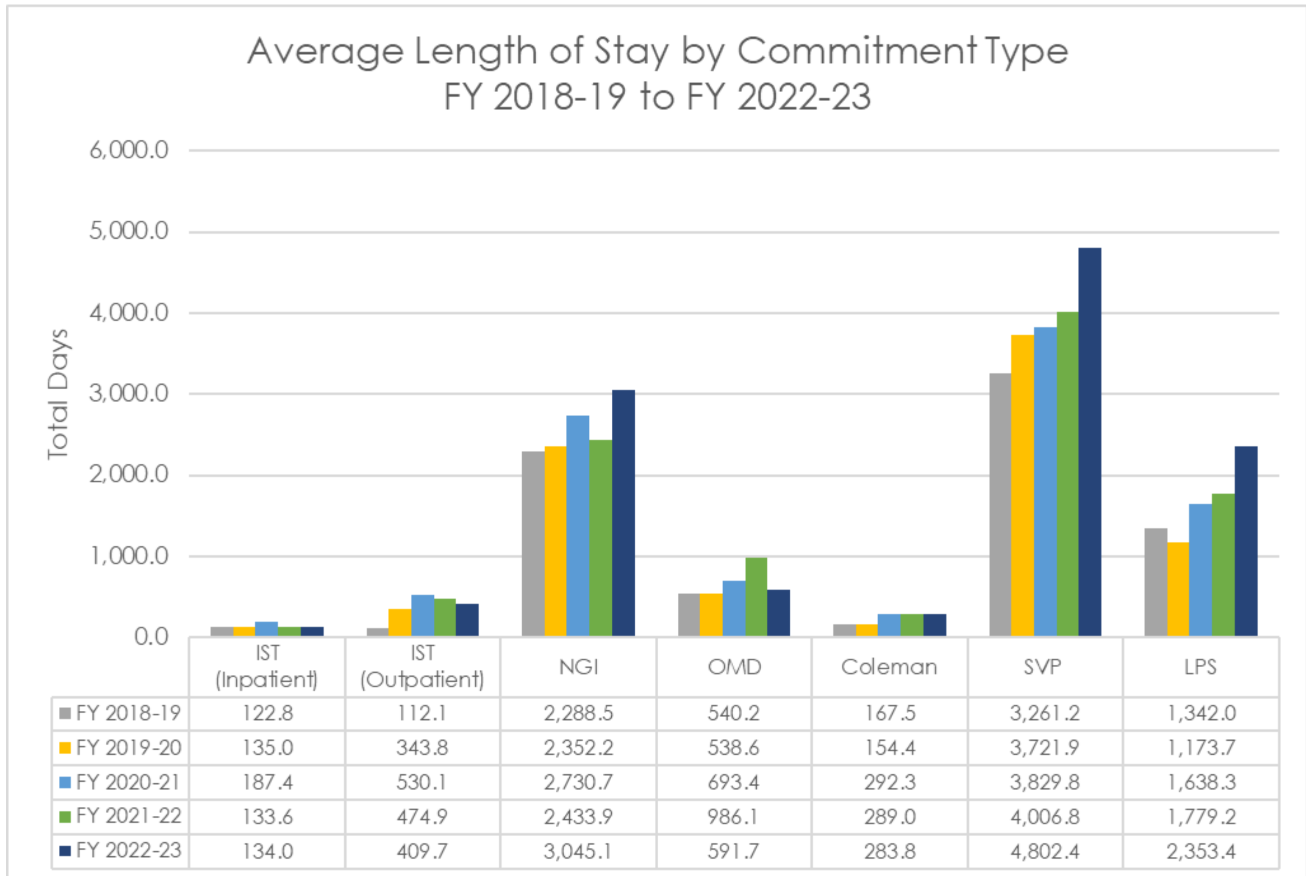
In FYs 2020-21 and 2021-22, COVID-19 impacted both admission rates and inpatient census. Admission rates decreased due to the implementaiton of a 10-day isolation period prior to transfer to a treatment unit, as well as continuous COVID-19 outbreaks requiring quarintines. Inpatient census was further impacted by the need to create Admission Observation Units (AOUs) and other spaces dedicated to isolating patients. The 16% growth from FY 2021-22 to FY 2022-23 reflects DSH's continuum of care and expansion of inpatient and outpatient programs, and a focus of growing

census while balancing continued health and safety measures associated with COVID-19.



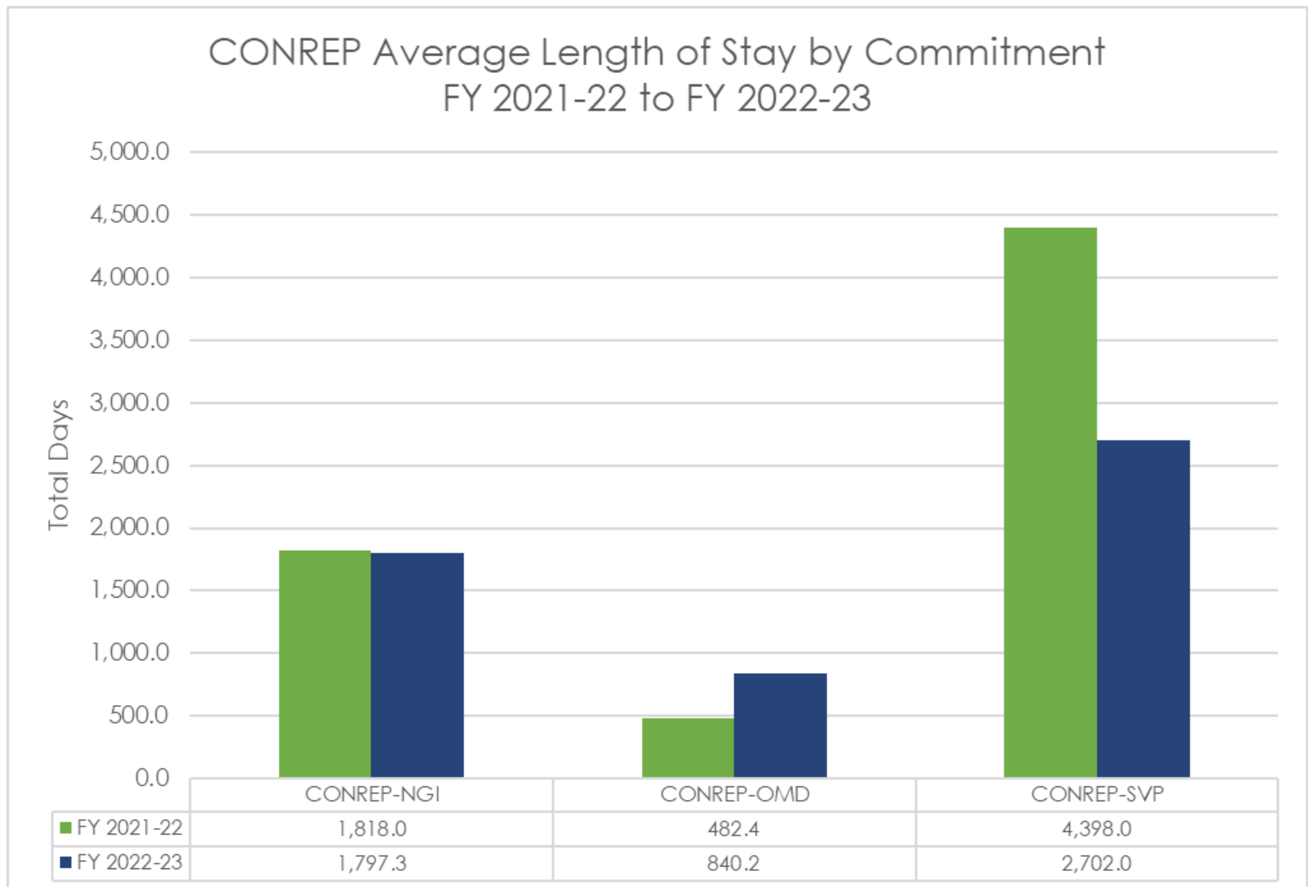
	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
IST (Inpatient)	5,694	5,090	4,241	5,030	6,412
IST (Outpatient)	165	270	506	889	1,206
NGI	1,568	1,530	1,506	1,871	1,834
OMD	2,008	1,815	1,673	1,622	1,596
Coleman	660	727	477	362	313
SVP	1,001	989	991	996	1,032
LPS	816	804	817	835	736
Total Served	11,912	11,225	10,211	11,605	13,129

Data includes State Hospitals data in all years and for all committments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT) Community. IST Outpatient includes Community Based Restoration all years. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP- Forensic Assertive Community Treatment Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22. Data excludes less than 11 Division of Juvenile Justice (DJJ) Patients in FY 2018-19 through FY 2022-23.



	IST (Inpatient)	IST (Outpatient)	NGI	OMD	Coleman	SVP	LPS
FY 2018-19	122.8	112.1	2,288.5	540.2	167.5	3,261.2	1,342.0
FY 2019-20	135.0	343.8	2,352.2	538.6	154.4	3,721.9	1,173.7
FY 2020-21	187.4	530.1	2,730.7	693.4	292.3	3,829.8	1,638.3
FY 2021-22	133.6	474.9	2,433.9	986.1	289.0	4,006.8	1,779.2
FY 2022-23	134.0	409.7	3,045.1	591.7	283.8	4,802.4	2,353.4

Data includes State Hospitals data in all years. Data includes State Hospitals data in all years and for all committments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT). IST Outpatient includes Community Based Restoration all years. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP- Forensic Assertive Community Treatment Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22.



	CONREP-NGI	CONREP-OMD	CONREP-SVP
FY 2021-22	1,818.0	482.4	4,398.0
FY 2022-23	1,797.3	840.2	2,702.0

IST patients treated in CONREP are reflected in the IST (Outpatient) graph above.

STATE HOSPITALS
BUDGET CHANGE PROPOSALS

There are no Budget Change Proposals (BCPs) proposed in the 2024-25 Governor's Budget.

STATE HOSPITAL
DSH – METROPOLITAN INCREASED SECURE BED CAPACITY
Program Update

SUMMARY

The Department of State Hospitals (DSH)-Metropolitan Increased Secure Bed Capacity (ISBC) project continues to experience delays in the activation of the remaining units for Incompetent to Stand Trial (IST) forensic patients. The roof replacement on the Skilled Nursing Facility (SNF) building is projected to be complete March 2024, allowing Units 4 and 5 to be activated for IST patients in May 2024. The 10-month delay in activation will result in a one-time savings of $9.6 million in fiscal year (FY) 2023-24.

BACKGROUND

To provide additional capacity to address the ongoing system-wide forensic waitlist, particularly focusing on the IST patient waitlist, the Budget Act of 2016 included capital outlay construction funding for the Increased Secure Bed Capacity (ISBC) project at DSH-Metropolitan. This project added security fencing and infrastructure for existing patient buildings at the hospital, which had primarily been used to house civilly committed Lanterman-Petris-Short (LPS) patients.

Construction of all five ISBC units is complete; however, as of the Budget Act of 2022, DSH had activated two of five units for the treatment of IST patients. The remaining three units were utilized to accommodate various operational needs related to DSH's COVID-19 response, the Continuing Treatment East (CTE) Fire Alarm Project, and to provide temporary housing to DSH-Metropolitan SNF patients while their building remains under construction/repairs.

As of the Budget Act of 2023, Unit 3, previously utilized for COVID-19 isolation space, was activated for treatment of IST patients. Units 4 and 5 continued to be utilized as temporary housing for SNF patients. DSH and Department of General Services (DGS) anticipated repairs to the DSH-Metropolitan SNF Building to be completed in July 2023, allowing Units 4 and 5 to be utilized for IST forensic patients as originally intended.

JUSTIFICATION

Construction progress on the SNF building continues to be impacted by the difficulties facing contractors in acquiring personnel and construction materials necessary for project completion. Additionally, several rain events in 2023 caused additional delays, requiring DSH-Metropolitan to continue utilizing Units 4 and 5 to house SNF patients.

Due to ongoing construction delays, as of the 2024-25 Governor's Budget, DSH and DGS expect the SNF building roof repairs to be completed in March 2024. Consequently, Units 4 and 5 are expected to be activated for IST patients in May 2024, resulting in a one-time savings of $9.6 million in FY 2023-24. An update will be provided in the 2024-25 May Revision.

Activation Timeline Adjustment

Unit	# of Beds	Scheduled Activation as of 2023-24 May Revision	Scheduled Activation as of 2024-25 Governor's Budget	Change from the 2023-24 May Revision
Unit 1	46	September 23, 2019	September 23, 2019	No change - Activated
Unit 2	46	January 29, 2020	January 29,2020	No change - Activated
Unit 3	46	November 1, 2022	November 1, 2022	No change - Activated
Unit 4	48	July 2023	May 2024	10-month delay
Unit 5	48	July 2023	May 2024	10-month delay

Resource Table

Description	CY	BY	BY+
Current Service Level	$74,857	$74,857	$74,857
Governor's Budget Request	-$9,552	$0	$0
TOTAL	**$65,305**	**$74,857**	**$74,857**

*Dollars in thousands

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
Program Update

SUMMARY

The Department of State Hospitals (DSH)-Patton Enhanced Treatment Program (ETP) unit, Unit 06, construction continues to be scheduled for completion in March 2024, with unit activation in May 2024.

BACKGROUND

The ETP was developed to accept patients who are at the highest risk of violence and cannot be safely treated in a standard treatment environment. The Budget Act of 2018 authorized DSH to construct four ETP units; three 13-bed units at DSH-Atascadero to serve male patients and one 10-bed unit at DSH-Patton to serve female patients. ETP Unit 29 at DSH-Atascadero was activated in September 2021, while construction for Units 33 and 34 was postponed due to bed capacity pressures associated with Incompetent to Stand Trial (IST) referrals.

In the Budget Act of 2023, DSH reflected a one-time savings of $3.2 million in FY 2023-24 associated with personal services savings due to continued challenges with the fire sprinkler redesign and regulatory approval at DSH-Patton. Unit construction was scheduled to be completed in March 2024 with unit activation in May 2024.

JUSTIFICATION

Demolition and ETP construction in the North wing began in March 2023. Fire sprinkler redesign and State Fire Marshal processes continue for DSH-Patton Unit 06. The project timeline remains unchanged, with construction estimated for completion in March 2024, followed by unit activation in May 2024.

Please see the table below for a complete activation timeline. DSH will provide an update in the 2024-25 May Revision.

ETP Activation Timeline			
Units/Hospital	**Scheduled Initiation**	**Scheduled Completion**	**Delay from 2023-24 May Revision**
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	July 2021 (Actual)	N/A
DSH-Patton Unit U-06	December 2023	May 2024	No change

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$11,936	$15,129	$15,129
Governor's Budget Request	$0	$0	$0
TOTAL	**$0**	**$0**	**$0**

*Dollars in thousands

STATE HOSPITALS
MISSION-BASED REVIEW – DIRECT CARE NURSING
Program Update

SUMMARY

The Department of State Hospitals (DSH) continues to phase in positions received as part of the Mission-Based Review (MBR) Staffing Study and reflects an additional one-time savings of $10.3 million in fiscal year (FY) 2023-24 due to delays in hiring Medication Pass Psychiatric Technicians (PT).

BACKGROUND

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. As part of the Direct Care Nursing component of the study, the Clinical Staffing Study reviewed current staffing standards and practices, proposed new data-driven staffing methodologies to adequately support the current populations served, assessed relief factor coverage needs, and reviewed current staffing levels within core clinical and safety functions.

A staffing standard was developed through research conducted within DSH's Clinical Staffing Study and in collaboration with the Department of Finance (DOF) Research and Analysis Unit through a Mission-Based Review. The proposal examined nurse-to-patient ratios for providing 24-hour nursing care and the components available to achieve these ratios including internal registries, overtime, temporary help, and position movements among facilities. The proposal additionally presented staffing methodologies for the administration of medication and the afterhours nursing supervisory structure.

The Budget Act of 2019 included a total of 379.5 positions and $46 million, phased in across a three-year period, to support the workload of providing 24-hour care nursing services within DSH.

In the Budget Act of 2021, all recruitment efforts were paused, and resources were shifted to focus on managing COVID-19 priorities and minimizing staff and patient exposure, delaying some position phase-ins. In the Budget Act of 2023, DSH projected a one-time savings of $4.8 million in FY 2023-24 due to delays in hiring.

JUSTIFICATION

Medication Pass Psychiatric Technicians (PT)

A total of 335.0 positions were allocated to Medication Pass PTs to be phased-in over four years.

As of August 31, 2023, all 335.0 positions have been phased-in, and 177.0 positions have been filled. DSH continues to actively recruit to fill these positions, however not all positions have been filled. As a result, DSH is projecting an additional one-time savings in FY 2023-24 of $10.3 million. To address ongoing recruitment challenges, DSH contracted with CPS HR Consulting for marketing and outreach to create digital ad campaigns and produce leads for multiple DSH classifications including PTs. Efforts are also underway to expand the PT pipeline, with DSH collaborating with PT Program Directors from various colleges, and other state agencies involved in workforce development to increase the overall admissions the colleges are experiencing for their respective PT programs, which will increase the potentially eligible individuals to be employed with DSH. DSH is also striving to streamline the hiring process, which DSH is now hosting rapid hiring events at each hospital location focused on providing same-day contingent offers.

Afterhours Supervising Registered Nurses (SRN)

A total of 44.5 positions were allocated to Afterhours Supervising Registered Nurses to be phased in over two years.

As of August 31, 2023, all position phase-ins are complete.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$42,287	$47,068	$47,068
Governor's Budget Request	-$10,290	$0	$0
TOTAL	**$31,997**	**$47,068**	**$47,068**

*Dollars in thousands

STATE HOSPITALS
MISSION-BASED REVIEW – TREATMENT TEAM AND PRIMARY CARE
Program Update

SUMMARY

The Department of State Hospitals (DSH) continues to phase in positions received as part of the Mission-Based Review (MBR) Staffing Study but continues to experience challenges with hiring the newly authorized positions. In the 2024-25 Governor's Budget, DSH reflects a one-time savings of $5.3 million in fiscal year (FY) 2023-24 due to delays in hiring phased-in positions.

BACKGROUND

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five State Hospitals. As part of the Treatment Team component of the study, the Clinical Staffing Study reviewed current staffing standards and practices, proposed new data-driven staffing methodologies to adequately support the current populations served, assessed relief factor coverage needs, and reviewed current staffing levels within core clinical and safety functions. As part of DSH's staffing study efforts, and in collaboration with the Department of Finance (DOF) Research and Analysis Unit through a Mission-Based Review, the four core areas of Treatment Planning and Delivery were examined:

- Interdisciplinary treatment team caseload ratios and categorization of treatment and treatment units
- Primary care delivery and physician caseload
- Clinical leadership structure
- Clinical programs and best practices

The Budget Act of 2021 included a total request of 250.2 positions and $64.2 million, phased in across a five-year period, to support the workload of providing psychiatric and medical care treatment to patients committed to DSH.

In the Budget Act of 2022, due to the delays and challenges in hiring, DSH shifted 29.5 of positions that were scheduled to be authorized in FY 2022-23 to January 1, 2026 (FY 2025-26) to allow time to recruit for positions already authorized.

In the Budget Act of 2023, DSH shifted 46.5 positions scheduled to be phased-in FY 2023-24 to FY 2026-27. This provided $10.9 million in savings per year until the phase-ins resume. Furthermore, DSH projected a one-time savings of $8.4 million in FY 2023-24 due to delays in hiring.

JUSTIFICATION

Interdisciplinary Treatment Team

A total of 180.4 positions were allocated to support the Interdisciplinary Treatment Team to be phased in over five years. As of August 31, 2023, a total of 52.8 positions have been established.

DSH is actively recruiting to fill these positions, however, has experienced challenges in hiring the newly added positions. To address ongoing recruitment challenges, DSH contracted with CPS HR Consulting to increase digital advertising to reach over 700 training programs throughout the country. Additionally, DSH has participated in multiple virtual job fairs and recruitment events and continues to do so.

DSH also continues to cultivate community and educational partnerships, and recruit for upcoming psychiatry residency cohorts. Based off the success of the psychiatry residency implemented at DSH-Napa, the Budget Act of 2023 provided resources to develop an additional psychiatric residency program at DSH-Patton. DSH also received resources to develop or expand[1] upon existing fellowship programs across all five State Hospitals, to provide clinicians opportunities to gain experience and familiarity with forensic populations, increasing the likelihood they will continue to work with these populations at DSH post-residency.[2]

Recently, various treatment team bargaining unit agreements were approved to increase compensation levels for multiple treatment team classifications including, but not limited to, psychiatrists, physicians, surgeons, psychologists, and rehabilitation therapists. Compensation levels were increased via General Salary Increases, Special Salary Adjustments, when completing additional caseload, and retention bonuses.

Primary Medical Care

A total of 31.9 positions were allocated to support Primary Medical Care to be phased in over three years.

As of August 31, 2023, all positions have been established and 10.5 positions have been filled. DSH is actively recruiting to fill these positions, despite continuous hiring challenges. As a result, DSH is projecting a one-time savings in FY 2023-24 of $4.1 million.

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[1] DSH currently partners with University of California, Davis (UC Davis) to provide training to four forensic fellows a year at DSH-Napa.

[2] For updates on the resources provided in the Budget Act of 2023 as part of the DSH 2023-24 Psychiatry Workforce Pipeline, Recruitment, Hiring and Retention Budget Change Proposal (BCP), please see Section D4, Workforce Development.

Primary Medical Care	Total	Filled
Chief Physician & Surgeon	6.1	4.0
Physician & Surgeon	25.9	6.5
TOTAL	**31.9**	**10.5**

Trauma-Informed Care

A total of 6.0 positions were allocated to support Trauma-Informed Care to be fully phased in beginning of FY 2021-22.

As of August 31, 2023, all position phase-ins are complete.

Clinical Executive Structure

The Clinical Executive Structure is needed to establish standard practices and procedures, provide leadership to staff and supervisors, and engage in administrative tasks such as focused efforts on recruitment and retention.

Administrative Support Positions

A total of 6.0 positions were allocated to support Administrative Services to be fully phased in beginning of FY 2021-22.

As of August 31, 2023, all position phase-ins are complete.

Clinical Executive Leadership

A total of 12.0 positions were allocated to support Clinical Executive Leadership to be fully phased in beginning FY 2021-22.

As of August 31, 2023, all 12.0 positions have been established and 7.0 have been filled. As a result, DSH is projecting a one-time savings in FY 2023-24 of $1.2 million.

Clinical Executive Leadership	Total	Filled
Medical Director	6.0	4.0
Assistant Medical Director	1.0	0.0
Chief of Primary Care Services	5.0	3.0
TOTAL	**12.0**	**7.0**

Discharge Strike Team

A total of 6.0 positions were allocated to support the Discharge Strike Team to be fully phased in beginning FY 2021-22.

As of August 31, 2023, all position phase-ins are complete.

Resource Table

Description	CY	BY	BY+
Current Service Level	$22,254	$38,421	$49,698
Governor's Budget Request	-$5,285	$0	$0
TOTAL	**$16,969**	**$38,421**	**$49,698**

*Dollars in thousands

STATE HOSPITALS
PATIENT-DRIVEN OPERATING EXPENSES & EQUIPMENT
Program Update

SUMMARY

The Department of State Hospitals (DSH) requests $10.8 million in fiscal year (FY) 2023-24 and ongoing to support patient-related operating expenses and equipment (OE&E) costs. Recognized costs are attributed to inflation and increases in hospital patient census.

BACKGROUND

The Budget Act of 2019 adopted a standardized methodology to provide funding for patient-related OE&E items such as outside medical care, pharmaceuticals, patient clothing, foodstuffs, etc. based on updated census estimates for each fiscal year and an estimated cost per patient, derived from past year actual expenditures. Throughout the COVID-19 pandemic and subsequent rising inflation[1], DSH has closely monitored these expenditures.

In the Budget Act of 2023, DSH received $26.6 million for FY 2023-24 and ongoing based on FY 2021-22 actuals and projected patient census.

JUSTIFICATION

As of the 2024-25 Governor's Budget, DSH requests $10.8 million in FY 2023-24 and ongoing. Following the methodology adopted in the Budget Act of 2019, patient-driven OE&E estimated costs for FY 2023-24 and FY 2024-25 are based on updated census projections and per patient costs derived from FY 2022-23 actual expenditures.

Increase in Per Patient Cost

Rising global inflation continues in 2023, resulting in cost increases nationwide. Correspondingly, the per patient cost has continued to rise, specifically in areas such as utilities and foodstuffs.

The chart below displays the rising costs of Utilities, Foodstuffs, and Pharmaceuticals impacting the DSH per patient cost from FY 2021-22 to FY 2022-23.

[1] Please see Department of Finance Budget Letters (BL) 22-22, 2023-24 Price Letter and BL 23-22, 2024-25 Price Letter, reflecting the impacts of inflation on rising costs.

Figure 1: All State Hospitals			
Budget Categories	FY 2021-22 Avg. Cost Per Patient	FY 2022-23 Avg. Cost Per Patient	Percentage Change FY 2021-22 to FY 2022-23
State Hospital Census	*5,318*	*5,689*	*7%*
Utilities	$4,188	$4,987	19%
Foodstuffs	$3,972	$4,469	13%
Pharmaceuticals	$7,375	$7,620	3%

Allotment Adjustment for FY 2023-24

The 2023-24 May Revision calculated a per patient cost of $25,792 and projected a patient census of 5,724 in FY 2023-24. Since that time, both the projected patient census and the costs of goods and services have increased, requiring additional funding.

Between FY 2021-22 and FY 2022-23, the per patient cost for Utilities, Foodstuffs, and Pharmaceuticals increased by $1,541. The projected patient census for FY 2023-24 also increased from the 2023-24 May Revision projection of 5,724 to the current projection of 5,839, an increase of 115. To calculate the additional funding need in these areas, the adopted methodology follows a two-step process:

- Step One: The first step is calculating the additional need resulting from the increased per patient cost. The per patient cost difference for Utilities, Foodstuffs, and Pharmaceuticals ($1,541) is multiplied by the 2023-24 May Revision projected census (5,724), resulting in $8,821,000.

- Step Two: The second step is calculating the additional need resulting from the increase in patient census. The updated per patient cost for Utilities, Foodstuffs, and Pharmaceuticals ($17,076) is multiplied by the increase in patient census (115), resulting in $1,963,000.

The total cost adjustment is determined by adding the results of steps one and two above. The table below displays the funding need for FY 2023-24 resulting from the increased per patient cost and updated census projection.

FY 2023-24 Total Cost Adjustment	
Cost Adjustment for Increased Per Patient Cost[2]	$8,821,000
Cost Adjustment for Updated Census[3]	$1,963,000
Total Request for FY 2023-24	**$10,784,000**

Allotment Adjustment for FY 2024-25

DSH projects the FY 2024-25 patient census to remain at 5,839 patients. Given no projected change to the census in FY 2024-25, DSH requests no additional funding for patient-driven OE&E.

As of the 2024-25 Governor's Budget, DSH requests a total of $10.8 million in FY 2023-24 and ongoing based on the updated per patient cost and census projections. DSH will continue to monitor costs and patient census and provide an update in the 2024-25 May Revision.

Resource Table

Description	CY	BY	BY+
Current Service Level	$135,891	$135,891	$135,891
Governor's Budget Request	$10,784	$10,784	$10,784
TOTAL	**$146,675**	**$146,675**	**$146,675**

*Dollars in thousands

[2] Total only includes per patient costs associated with Utilities ($4.6M), Foodstuffs ($2.9M), and Pharmaceuticals ($1.4M)

[3] Total only includes increased census costs associated with Utilities ($573,000), Foodstuffs ($514,000), and Pharmaceuticals ($876,000)

STATE HOSPITALS
INFECTIOUS DISEASE PREVENTION (COVID-19) UPDATE
Program Update

SUMMARY

The Department of State Hospitals (DSH) requests $25.9 million in fiscal year (FY) 2024-25, and $7.7 million in FY 2025-26 and ongoing for expenditures related to infection control measures which continue in the DSH hospital system following the end of the COVID-19 State of Emergency, in order to continue to protect the health and safety of DSH staff and patients.

BACKGROUND

DSH executed a COVID-19 response plan across its system to follow guidance from the California Department of Public Health (CDPH), the Centers for Disease Control and Prevention (CDC), and other state and local partners. Under these circumstances, DSH took the necessary steps to mitigate the spread of COVID-19 at all facilities, including implementation of policies and procedures for infection control, respiratory protection, COVID-19 testing, personal protective equipment (PPE), and established isolation units.

Although the California State of Emergency ended on February 28, 2023, and the Federal State of Emergency ended on May 11, 2023, DSH has an ongoing responsibility to protect the health and safety of staff and patients from aerosol transmissible diseases (ATD). Based on the changes in operations made by DSH in accordance with the CDC, CDPH, Cal/OSHA, and local public health guidance, DSH has continued to prioritize the safety of its employees and patients through infection control measures, thereby mitigating the spread of COVID-19 and other infectious diseases throughout DSH facilities. This request ensures DSH will continue to be able to maintain the health and safety of staff and patients in the event of any disease outbreak, mitigate the impact to our aging population during seasonal infectious disease outbreaks or peak seasons, and maintain safe working conditions to foster a therapeutic environment free from emotional and physical harm for all patients and employees.

In the Budget Act of 2023, DSH received one-time funding of $42.1 million in FY 2023-24 to continue to support infection control measures to protect the health and safety of employees and patients beyond the State of Emergency end date.

JUSTIFICATION

As of the 2024-25 Governor's Budget, DSH requests $25.9 million in FY 2024-25 and $7.7 million ongoing to continue to support infection control measures to protect the

health and safety of its employees and patients in compliance with CDPH, Cal/OSHA, and CDC guidance. The resources included those needed to support testing, surge resources, public health related personnel, cleaning, and commodity goods which will facilitate compliance with the following regulatory requirements.

- Title 8, section 5199 of the Health and Safety Code, which outlines requirements health care facilities must follow to address the risk of aerosol transmissible disease exposure and the control measures that must be in place.
- Various CDPH All Facilities Letters (AFL) which require continued monitoring of COVID-19 case rates and prevention activities as well as other respiratory illnesses including influenza and respiratory syncytial virus (RSV).
- The Public Health Nurses are responsible for the ongoing administration, monitoring, tracking, reporting, and managing of vaccines, as well as outbreak tracking and reporting to local public health agencies as proscribed by the AFLs.
- Effective January 1, 2023, all healthcare providers must report vaccine administration information to the California Immunization Registry (CAIR) for every vaccine administered (Health and Safety Code section 120440, also addressed in AFL 23-26).

Testing

The purpose of a diagnostic screening testing is to detect new cases, prevent exposure, and mitigate outbreaks. Congregate living environments, such as DSH, have an increased risk for rapid and widespread transmission of COVID-19. A strategy of frequent testing is recommended to reduce the chance of a large outbreak when a COVID-19 exposure occurs, and when contact tracing is difficult to perform. This is especially relevant as COVID-19 has a high proportion of asymptomatic cases.

DSH continues testing throughout its hospital system for both patients and staff. This includes both Rapid Antigen Test (RAT) and polymerase chain reaction (PCR). Continued testing will be required as different variants arise and outbreaks occur, therefore, DSH requests $10.0 million in FY 2024-25 to procure tests and the associated materials needed.

Surge Capacity Resources

Hospital Staffing

As COVID-19 and other infectious disease cases increase and staff are off work, DSH is required to maintain staffing to meet bed licensing and staffing minimums. Based on trends observed over the past three years of the pandemic, DSH has experienced surges in the winter and summer months. To account for these spikes in cases and

necessary time for staff to be off work, DSH is requesting $4.7 million in FY 2024-25 to provide contracted short-term staffing support during surges.

Norwalk Alternate Care Site (ACS)

In response to COVID-19, DSH entered into an Interagency Agreement (IA) with the California Department of Corrections and Rehabilitation (CDCR) to utilize a portion of the Southern Youth Correctional Reception Center and Clinic in Norwalk, CA. The ACS operates as a satellite facility to DSH-Metropolitan and features two housing units (one 50-bed and one 48-bed), plus a separate building for treatment and office space. The ACS provides additional space when DSH experiences an influx of positive patients and quarantined units. The original Norwalk IA was extended, and the current contract is in effect until December 31, 2024. To continue to utilize this additional facility, DSH requires resources for personnel, operating expenses, and equipment. DSH is requesting $3.5 million in FY 2024-25 to provide this support, in line with the existing IA contract dates.

<u>Vaccinations</u>

For the state hospitals to remain in compliance with Title 8, Section 5199 of the Health and Safety Code, DSH must manage the risk of aerosol transmissible disease exposure and implement effective infection control measures. Vaccination programs are one of the most effective services of public health promotion and infectious disease prevention. In addition to ongoing provision of COVID-19 vaccines, the annual influenza vaccination campaign runs from October through April of each year in compliance with county public health orders for the respiratory virus season.

In addition to providing comprehensive influenza and COVID-19 vaccination programs, DSH hospitals are also required to offer vaccinations for other infectious and/or aerosol transmissible diseases to patients and employees, including Hepatitis B, Tetanus/diphtheria/Acellular Pertussis (Tdap), Measles/Mumps/Rubella (MMR), and Varicella-zoster (VZV).

COVID-19 vaccines were previously provided through CDPH at no cost to DSH. However, DSH must now purchase COVID-19 vaccines, along with the other vaccines provided to patients and staff. To support these efforts, DSH requests $3.8 million in FY 2024-25 and ongoing to support COVID-19 vaccination costs in order to continue to administer vaccinations for infectious and/or aerosol transmissible diseases for the health and safety of patients and staff.

Public Health Teams

Public Health Nurses

DSH Public Health Teams lead the Department's immunization programs, including the provision of COVID-19 and influenza vaccines to patients and staff. Public health personnel not only administer vaccinations but also provide continuous education regarding vaccination benefits. This includes addressing misinformation regarding COVID-19 and influenza vaccines, building vaccine confidence, and ensuring only the most reliable, up to date education is provided. Accurate clinical guidance must be provided to each individual involved regarding isolation requirements, health care follow up, testing for return-to-work requirements, continued patient and staff surveillance, and education to ensure compliance. Public health staff complete an average of 1-10 case investigations per day, and during surges, as many as 15-20. A strong case investigation and contact tracing system must be maintained to slow the spread of infectious diseases and is a required public health measure.

Since Public Health Teams provide continuous vaccination education and other public health outreach to DSH workforce members, Public Health Teams must stay informed of current vaccine guidance and clinical considerations. Various CDPH AFLs require continued monitoring of COVID-19 case rates and prevention activities as well as other respiratory illnesses including influenza and RSV. These include AFL 20-43.4, which requires state hospitals that have CMS-certified skilled nursing beds to report COVID-19 data weekly to the federal Department of Health and Human Services; AFL 21-08.9, which guides quarantine and isolation requirements for healthcare personnel exposed to COVID-19 and those returning to work after COVID-19 illness; and AFL 22-33.1, which addresses planning for and responding to surges due to increases in COVID-19, influenza, and other respiratory viruses.

Public Health Nurses (PHNs) have a critical role in the development of each state hospital's Aerosol Transmissible Disease Plan and the ongoing implementation, monitoring, and updating of the plan. In addition, PHNs are responsible for the ongoing administration, monitoring, tracking, reporting, and managing of vaccines, as well as outbreak tracking and reporting to local public health agencies. This includes ensuring eligible patients are offered COVID-19 vaccinations prior to discharge in compliance with AFL 21-20.2, and that COVID-19 vaccinations and booster doses are offered to clinically eligible individuals in accordance with AFL 22.09-1.

Effective January 1, 2023, all healthcare providers must report vaccine administration information to the CAIR for every vaccine administered. (Health and Safety Code section 120440, also addressed in AFL 23-26). This change is applicable to vaccinations administered to patients and employees. As a result, Public Health teams must track when and which patients are due for the initial COVID-19

vaccination series and other doses to stay up to date. With new hospital admissions each week, this is a continuous effort and increased workload for the PHNs. Hospitals must continue to offer vaccines to patients who refuse multiple times, while documenting refusals and continuing to coordinate education efforts with the patient's treatment team. Requirements for reporting COVID-19 outbreaks to local health departments and to CDPH Licensing and Certification District Offices are outlined in AFL 23-09.

Currently DSH has 10.0 limited term PHN positions to ensure compliance with the additional workload tied to vaccination and monitoring functions. To continue these functions, DSH requests permanent position authority for 10.0 positions and $1.9 million in FY 2024-25 and ongoing.

Commodity Goods

Many required items such as personal protective equipment (PPE) are increasingly unavailable through statewide stockpiles or through other state departments. However, due to the continuation of testing and vaccination guidelines outlined above, DSH will continue to frequently utilize PPE such as gloves, gowns, surgical masks, N95 masks, protective clothing, and face shields. Additionally, due to the increased cleanings and additional teams requested, DSH will need to increase sanitation supplies such as germicidal bleach, hand sanitizer, and hydrogen peroxide wipes. DSH dining rooms are closed when infections spike in the facility. However, when dining rooms are open, quarantined patient units and isolated patients cannot eat in the dining rooms. In these instances, patients are served food on the housing units. This drives a need for food supplies and meals to be individually packaged, and items normally available for communal use need to be served individually. As such, DSH requests $2.0 million in FY 2024-25 and ongoing for tangible goods and operating expenses, which are generally consumable in nature and require continuous replenishment.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$42,062	$0	$0
Governor's Budget Request	$0	$25,900	$7,700
TOTAL	**$42,062**	**$25,900**	**$7,700**

*Dollars in thousands

FORENSIC CONDITIONAL RELEASE PROGRAM (CONREP) GENERAL/NON-SEXUALLY VIOLENT PREDATOR (NON-SVP) PROGRAM

Program Update

SUMMARY

As of the 2024-25 Governor's Budget, the Department of State Hospitals (DSH) reports a one-time savings of $599,000 in fiscal year (FY) 2023-24 due to delays in admissions at the Northern CA Statewide Transitional Residential Program (STRP) facility. While DSH anticipates a total contracted caseload of 1,038 in FY 2023-24 and 945 in FY 2024-25, prior expansions to the program have increased the workload for program support and operations.

BACKGROUND

CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. CONREP aims to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system. The CONREP Non-SVP population includes clients deemed Not Guilty by Reason of Insanity (NGI), Offender with a Mental Health Disorder (OMD), and felony Incompetent to Stand Trial (IST)[1] patients who have been court-approved for outpatient placement in lieu of state hospital placement. Individuals suitable[2] for CONREP may be recommended to the courts by the state hospital Medical Director.

Currently, DSH contracts with seven county-operated and eight private organizations to provide outpatient treatment services to non-SVP clients in all 58 counties of the state. Contractors complete regular treatment evaluations and assessments in conjunction with the court-approved treatment plan and provide forensic mental health treatment in individual and group therapy settings, in additional to various services needed to support community reintegration including:

- Life skills training
- Residential placement
- Collateral contacts (e.g., other individuals/agencies)
- Home visits
- Substance abuse screenings
- Psychiatric services
- Case management
- Court reports
- Psychological assessments

[1] The Budget Act of 2022 amended PC Section 1370 to statutorily prioritize community outpatient treatment effective July 1, 2023[1], increasing consideration for placement of IST patients in community IST facilities.

[2] As specified in PC 1600-1615 and 2960-2972, the CONREP Community Program Director (CPD), with the Court's approval (or in the case of OMDs, the Board of Parole Hearings (BPH) approval), assesses and makes the recommendation for individuals' placement in CONREP.

When a DSH patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. Historically, CONREP's model of care is a centralized outpatient clinic where most treatment services are delivered. In this treatment model, clients must seek transportation or walk to access these services, requiring them to live close to the outpatient clinic or along a major bus route to access timely treatment regularly. As it is impractical to place individuals in areas which require a client to navigate multiple bus routes or obtain a costly taxi ride, the current type of service model limits the inventory of housing secured for the placement of CONREP clients.

Step-Down Transitional Program

CONREP-eligible clients who may not need a locked setting but have not demonstrated the ability to live in the community without direct staff supervision may participate in the Statewide Transitional Residential Program (STRP). STRP is an interim housing environment with 24 hours-per-day, seven days-per-week (24/7) supervision, which allows clients to learn appropriate community living skills while transitioning from a state hospital setting. Client stays are based on availability, and typically limited to 90 to 120 days but may be extended due to medical necessity. Once clients are ready to live in the community without structured 24/7 services, they are eligible for transfer to a Board & Care, Room & Board, or other community living arrangement without ongoing direct supervision.

CONREP Forensic Assertive Community Treatment (FACT) Regional Program (CFRP)

The CONREP FACT Regional Program (CFRP) is a 24/7 mobile treatment team providing onsite individual and group treatment to clients at their residence. In addition to providing treatment, CFRP's mobility allows them to respond quickly to provide de-escalation and crisis intervention practices, reducing the likelihood of rehospitalization. DSH has contracted with a provider for up to 180 dedicated beds and staff resources for this new treatment option in CONREP across three regions of the state: Northern California, Bay Area, and Southern California.

In addition to increasing the placement options available for NGI and OMD patients transitioning from the state hospitals, the FACT model of care can be used to treat IST clients ordered to CONREP when other community-based restoration programs are not available.

In the Budget Act of 2023, DSH received $2.6 million and 2.0 positions to build out its continuum of care and respond to the increase in the CONREP non-SVP census and associated workload.

JUSTIFICATION

As of the 2024-25 Governor's Budget, DSH anticipates a total contracted caseload of 1,038 CONREP clients in FY 2023-24 and 945 in FY 2024-25. This contracted caseload includes 674 regular CONREP clients currently placed in settings which do not offer dedicated beds to the program. In addition, CONREP's contracted caseload includes the following current and planned specialized beds dedicated to the program:

- 55 STRP beds in FY 2023-24
  - o 35-bed activated Southern CA STRP
  - o 20-bed activated Northern CA STRP
- 90 FACT beds
  - o 30 activated beds in Central CA in FY 2022-23
  - o 60 beds activated in Northern CA and Southern CA in FY 2021-22
- 132 Institute for Mental Disorder (IMD) beds in FY 2023-24
  - o 78-bed Southern CA IMD activated in October 2023
  - o 24-bed activated Southern CA IMD (to be transitioned to Community Inpatient Facility in October 2023)
  - o 30-bed activated Northern CA IMD

This contracted caseload reflects the total number of clients and beds available by the end of FY 2023-24 and FY 2024-25, which may vary based on activation delays. Reflecting the projected client phase-in, DSH estimates an average census of 856 in FY 2023-24 and 858 in FY 2024-25.

78-Bed Southern CA IMD Facility (Golden Legacy)

Using space previously licensed as a skilled nursing facility (SNF), and in partnership with a Southern CA IMD facility, Golden Legacy, DSH developed plans for a 78-bed step-down program for OMD and NGI state hospital patients ready for CONREP in 18 to 24 months. Construction activities began in January 2022, with anticipated program activation to occur in August 2022. However, physical space modifications required to assure the safety and security of the clients, coupled with supply chain and labor shortages related to the COVID-19 pandemic, and licensing requirements have further delayed program activation.

During construction, DSH worked closely with Golden Legacy on program planning and startup activities. To avoid further delays, the program is expeditiously working on the recruiting, hiring, and training of staff. Additionally, Golden Legacy developed a proactive patient referral process and is identifying prospective patients for transfer to facilitate placement immediately upon activation. In addition, due to COVID-19 isolation protocols, the facility must temporarily convert two double rooms to single occupancy, thereby reducing bed capacity from 78 to 76 for the duration of the

pandemic. There are no savings associated with this temporary conversion, as this bed reduction does not reduce the staffing ratio.

In September 2023, the California Department of Public Health (CDPH) surveyed the facility and approved the necessary program licensing. Golden Legacy received approval from CDPH to activate Phase I (33 beds) in late September, and admissions began the first week of October. Golden Legacy will continue to review prospective patients for admissions from the state hospitals and the referral waitlist, with the goal of admitting up to 9 clients per week until they reach their full capacity. Of the 76 beds, 20 were filled by patients transferring from the adjacent Sylmar IMD program. Sylmar will then transition from a CONREP program to a 24-bed Community Inpatient Facility (CIF) program dedicated to serving IST patients. Please see the IST Solutions narrative in section C8 for additional details. As of November 2023, all 33 beds of Phase I have been filled and a waitlist for Phase II is active. Phase II activation is anticipated for late December dependent on CDPH survey and approval.

As of the 2024-25 Governor's Budget, DSH does not anticipate any funding adjustments for Golden Legacy. A one-time savings of $2.8 million in FY 2023-24 from the delayed program activation will be redirected and used to fund minor retrofitting expenses for Sylmar in preparation of serving a more acute population, as well as increased contract costs to support the following: the transition of the Sutter-Yuba CONREP program from a county-operated program to a private provider, the merge of the Solano and Sonoma CONREP programs, and increased staffing and operating costs for several other programs. As such, DSH proposes to utilize this current year savings to offset these costs.

30-Bed Northern CA IMD Facility (Canyon Manor)

In the 2023-24 May Revision, DSH and the provider expanded services to deliver treatment for an additional 10 beds, for a total caseload of 30 in FY 2023-24. As of November 2023, all 30 beds are filled or reserved for clients ready for placement pending a court-ordered release from the state hospital. The provider continues to evaluate additional clients for admission. As of the 2024-25 Governor's Budget, DSH does not anticipate any funding adjustments for the 30-bed IMD Facility.

20-Bed Northern CA STRP Facility (A&A Health Services)

In the 2023-24 May Revision, DSH and the provider reduced the bed capacity of the 30-bed STRP facility, while maintaining current staffing levels, resulting in a total caseload of 20 in FY 2023-24. In an effort to allow for further development and refinement of the STRP program, the provider paused admissions at the end of May 2023. As of October 2023, the provider has resumed reviewing client referrals and is currently reviewing the waitlist. As of November 2023, 8 beds are filled. The provider continues to evaluate additional clients for admission, with DSH anticipating the

remaining beds will be filled by January 2024. As of the 2024-25 Governor's Budget, DSH reports a one-time savings of $599,000 in FY 2023-24 as a result of the unfilled beds.

<u>CONREP FACT Regional Program (CFRP)</u>

The contracted CFRP provider has secured program housing in Sacramento, San Diego, and Alameda counties, all of which support a regional model of FACT programs that serve CONREP clients from across the state. As of November 2023, CFRP-Sacramento is at a reduced census of 18 clients due to staffing changes, as well as to allow for further program development and refinement of the program. CFRP-San Diego census is at 30. CFRP-Alameda activated in January 2023 and has filled 29 beds. The provider continues to evaluate additional clients for admission.

DSH initially contracted with a single FACT provider for up to 180 beds - 60 within each region - but experienced significant concerns with the housing locations secured by the provider and their level of staffing to appropriately meet the clinical needs and satisfy court report requirements of the patients treated within the FACT programs. DSH clinical and operational staff evaluated the program's operations over the course of nearly a year of providing close on-site supervision, outcomes monitoring, training, and technical assistance. Following this, DSH determined the provider needed to increase staffing levels to provide the requisite services, ensure a dedicated 24/7 clinical on-site presence, maintain service documentation, and complete and submit court reports timely. In addition, to ensure the safety of the clients and staff, two of the three regional programs relocated to alternate areas.

The increase in provider staffing and securing of more suitable housing in safer locations with appropriate on-site supports has improved services for CFRP patients but has also increased costs to maintain the program. Further, while DSH continues to monitor these changes to ensure the best patient care and outcomes, each regional program will maintain a maximum of 30 beds, for a total of 90 FACT beds statewide. This reduction in contracted beds is offset by the increased costs to support increased staffing levels and housing with onsite clinical supports and supervision that can appropriately respond to the treatment needs of patients 24/7. The Budget Act of 2022 provided $14.3 million in ongoing funding to support the CFRP and, when initially designed and implemented, was significantly understaffed to support the 24/7 nature of each regional program, spread across multiple homes within each region, especially as the programs serve more IST patients that typically need a higher level of services based on acuity. Reducing each program's capacity, coupled with increased staffing to support the populations, results in a ratio of approximately 7:1, whereas the previous staffing was a ratio of 12:1. As such, there are no anticipated savings.

Due to the recent statutory amendment to CA Penal Code 1370 (SB 1223, Chapter 735, Statutes of 2022) that, effective July 1, 2023, prioritizes and supports outpatient treatment, community treatment, and diversion for felony Incompetent to Stand Trial (IST) defendants, CONREP will be utilizing additional beds within its continuum of care programs to serve IST defendants, especially the CONREP FACT Regional Programs. It was determined during the most recent CFRP activation that DSH significantly underestimated the workload and dedicated personnel resources needed for program implementation and clinical oversight activities. Additionally, CFRP currently has the highest footprint and bed count within CONREP's continuum.

DSH will continue to monitor the need for additional workload support resources and provide an update in the 2024-25 May Revision.

<u>CONREP Supervised Release File (SRF) and Agency California Law Enforcement Telecommunications System (CLETS) Coordinator (ACC)</u>

The expansions of the CONREP continuum of care programs within recent years, and corresponding increases in new patient admissions, discharges, and transfers between programs, have significantly magnified the workload of CONREP Operations administrative staff. The IST patient population treated within CONREP has doubled in the span of only one year, and due to the shorter lengths of stays, the program has experienced a greater level of patient movement through the system. Additionally, as CONREP continues to refine its programming options to offer varying levels of care to meet the needs of NGI and OMD patients in the state hospitals who are ready to step down, DSH estimates the number of patients and rate of movement will continue to increase across the various CONREP treatment settings. Staff have specifically seen an increase in the time required for managing and updating the SRF due to an increase in volume in critical updates pertaining to admissions, discharges, Absent Without Leaves (AWOLs) and transfers, as well as ensuring DSH staff and contracted program staff have access to CLETS certification training, adhering to the Department of Justice's (DOJs) policies and procedures pertaining to sensitive criminal data information obtained via the SRF, and ensuring compliance with the DOJ's policies, procedures, and audits as the ACC. For context, DSH supported just under 350 SRF entries in 2022 as compared to more than 750 SRF entries in 2023 as of September 2023.

Currently, CONREP Operations does not have dedicated law enforcement staff, or the resources required to provide needed operational and administrative program support to the SRF, directly impacting client care. CONREP has had a significant increase in admissions, discharges, and AWOLs due to the increased numbers of ISTs being served across the programs. The required SRF updates are critical to client care in the community and to providing necessary information to law enforcement, in the event they have contact with a client being treated in the community. Dedicated staff are needed for the Agency CLETS Coordinator (ACC) role and SRF updates, to

track all patient movement in accordance with CA DOJ and FBI policies and regulations to ensure public safety. DSH will continue to monitor this workload and provide an update in the 2024-25 May Revision.

As of the 2024-25 Governor's Budget, DSH reports a one-time savings of $599,000 in FY 2023-24 due to delays in admissions at the Northern CA STRP facility.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$48,047	$48,508	$48,508
Governor's Budget Request	($599)	$0	$0
TOTAL	**$47,448**	**$48,508**	**$48,508**

*Dollars in thousands

FORENSIC CONDITIONAL RELEASE PROGRAM (CONREP)
SEXUALLY VIOLENT PREDATOR (SVP) PROGRAM
Program Update

SUMMARY

As of the 2024-25 Governor's Budget, the Department of State Hospital (DSH) projects a caseload of 31 Sexually Violent Predators (SVP)s to be conditionally released into the community by June 30, 2025.

BACKGROUND

The CONREP program is DSH's statewide system of community-based services for specified court-ordered forensic individuals. The SVP Act (Welfare and Institutions Code (WIC) section 6600, et. seq) went into effect January 1, 1996, with the first SVP client being placed in the CONREP-SVP program in 2003. Prior to 2003, existing CONREP providers did not have SVP-specific services to treat SVP clients, requiring DSH to contract with a single private provider serving all 58 counties.

When an SVP client is conditionally released into the community by court order, existing law requires they be released to their county of domicile, and that sufficient funding be available to provide treatment and supervision services. Clients in CONREP SVP are provided the same array of mental health services general non-SVP program clients are afforded. Additional required services for SVP clients in CONREP include regularly scheduled sex offender risk assessments, objective measures of sexual interests, polygraph testing, a Community Safety Team (CST), and Global Positioning System (GPS) data and surveillance.

In recent years, DSH has experienced significant community opposition in securing housing for SVP clients to be released into CONREP. Since the SVP law was enacted, the average timeframe is slightly less than 12 months from approved petition to placement in the community but in recent years, this average time to placement has been increasing. Effective January 1, 2023, new statutes resulting from the passage of Senate Bill (SB) 1034 (Atkins), Ch. 880, Statutes of 2022, requires DSH to convene a committee of specified county representatives to obtain relevant assistance and consultation regarding securing suitable housing for each client approved for conditional release. This committee is in effect from the date of the initial order approving placement in CONREP to the date of actual transition from the state hospital to the community through CONREP.

These new requirements provided for the establishment of county-specific Housing Committee Meetings (HCM)s that are open to the public, pursuant to the Bagley-Keene Open Meeting Act. This change has resulted in an increased number of court hearings, task and criteria tracking, reporting requirements, housing status reports to

the court, and inter-agency coordination across multiple counties throughout the state. As a result, the current average wait time for individuals who are approved for CONREP but pending a court-approved placement location is 20 months. As these new processes are refined and evolve, DSH will monitor for any potential impacts to the average placement waiting period that could result from implementation of the HCMs.

PROGRAM UPDATE

As of the 2024-25 Governor's Budget, 21 court-ordered clients are participating in CONREP-SVP, however, a small number of these individuals have been re-hospitalized and are pending potential re-release to the community in the current year. Additionally, 19 individuals with court-approved petitions are awaiting placement into the community and ten more have filed petitions and are proceeding through the court process. With the dynamic nature of the court process and timelines, challenges surrounding housing availability, and other factors, DSH projects an average caseload of 31 clients may be conditionally released to CONREP by the end of fiscal year (FY) 2024-25. Please refer to the table below which displays the total projected caseload for FY 2023-24 and FY 2024-25.

CONREP-SVP Projected Caseload for 2024-25 Governor's Budget		
Description	Projected Caseload as of FY 2023-24	Projected Caseload as of FY 2024-25
Individuals currently in CONREP[1]	21	21
Adjusted Caseload[2]	6	10
Total	**27**	**31**

DSH calculates the estimated projected caseload using the average number of months from the court-approved petition to CONREP placement, and considers other factors such as revocations, unconditional release from CONREP, and delays to court proceedings and/or community placement. As such, it is assumed that this estimated caseload number may change between the 2024-25 Governor's Budget and May Revision.

Due to the volatility of this projected caseload, no additional funding is requested at this time. DSH will closely monitor this caseload and provide an update in the 2024-25 May Revision.

[1] A portion of these individuals are not in the community and are pending the outcome of revocation hearings. The actual number is masked due to de-identification guidelines.
[2] Accounts for admissions and discharges over the course of the FY.

Resource Table

Description	CY	BY	BY+
Current Service Level	$12,680	$12,680	$12,680
Governor's Budget Request	$0	$0	$0
TOTAL	**$12,680**	**$12,680**	**$12,680**

*Dollars in thousands

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL SOLUTIONS
Program Update

SUMMARY

The Department of State Hospitals (DSH) continues its efforts to provide timely access to treatment for individuals who are found Incompetent to Stand Trial (IST) on a felony charge. As of the 2024-25 Governor's Budget, DSH requests position authority for 2.0 positions, while reporting a net savings of $58.6 million in fiscal year (FY) 2023-24 due to changes in implementation of various IST Solutions such as Jail-Based Competency Treatment (JBCT) programs, Community Inpatient Facilities (CIF) programs, and Early Access and Stabilization Services (EASS) programs. DSH will continue to monitor program activity and explore options for repurposing savings to further program goals and will provide an update in the 2024-25 May Revision.

BACKGROUND

The State of California has observed significant growth in the number of individuals found IST on felony charges and referred to DSH for competency restoration, with year-over-year growth in IST referrals outpacing the department's ability to create sufficient additional capacity. Prior efforts, including increased inpatient bed capacity, systems efficiencies resulting in decreased average length of stays (ALOS), and implementation of community-based treatment programs, had been insufficient to respond to the ever-growing demand, resulting in a waitlist and extended wait times for IST defendants pending placement into a DSH treatment program. Further compounding the issue, the COVID-19 pandemic and the adopted infection control measures required at DSH facilities contributed to significantly slower admissions and a reduction in the capacity to treat felony ISTs at DSH for the duration of the state of emergency, causing the IST waitlist and corresponding wait times to grow substantially.

In 2021, the Alameda Superior Court ruled in *Stiavetti v Clendenin*[1] that DSH must commence substantive treatment services to restore IST defendants to competency within 28 days from the transfer of responsibility to DSH[2], providing a specified timeline to meet that standard over three years, with February 27, 2024, as the target date for ultimately providing substantive treatment services for felony ISTs within 28 days of the transfer of responsibility. On October 6, 2023, the Alameda Superior Court modified the interim benchmarks and final deadline for compliance with the 28 days as follows:

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[1] In 2015, the American Civil Liberties Union filed a lawsuit against DSH (*Stiavetti v. Clendenin*), alleging the time IST defendants were waiting for admission into a DSH treatment program violated the IST defendant's constitutional right to due process.
[2] Date of service of the commitment packet to DSH for felony IST patients.

- March 1, 2024 – provide substantive treatment services within 60 days
- July 1, 2024 – within 45 days
- November 1, 2024 – within 33 days
- March 1, 2025 – within 28 days

Also in 2021, the Legislature enacted Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and DSH to convene an IST Solutions Workgroup (Workgroup) to identify short-, medium-, and long-term solutions to address the increasing number of individuals with serious mental illnesses (SMIs) who become justice-involved and deemed IST on felony charges. Following a series of meetings convened between August 2021 and November 2021 with relevant stakeholders, the Workgroup identified over 40 strategies and solutions to advance alternatives to placement in DSH competency restoration programs.

The Budget Act of 2022 (and subsequent adjustments authorized in the Budget Act of 2023) appropriated funding to implement many of the IST Solutions identified by the Workgroup. These included providing early stabilization to increase diversion opportunities and care coordination, expanding community-based treatment and diversion options for felony ISTs, improving IST discharge planning and coordination, implementing a pilot for Independent Placement Panels (IPP), and improving alienist training. These resources were combined with previously funded IST programs, including IST re-evaluation services, JBCT, and CIF, expanding the DSH continuum of care for IST individuals. Additionally, statutory changes aimed at solving the IST crisis have been implemented to streamline and improve IST processes, target the continued growth in IST determinations (felony IST growth cap), and establish a comprehensive set of strategies and solutions, ensuring felony IST individuals have timely access to appropriate treatment and services. Collectively, these strategies and solutions assist the state in meeting the court-ordered treatment timelines outlined in *Stiavetti v. Clendenin*.

<u>IST Waitlist</u>

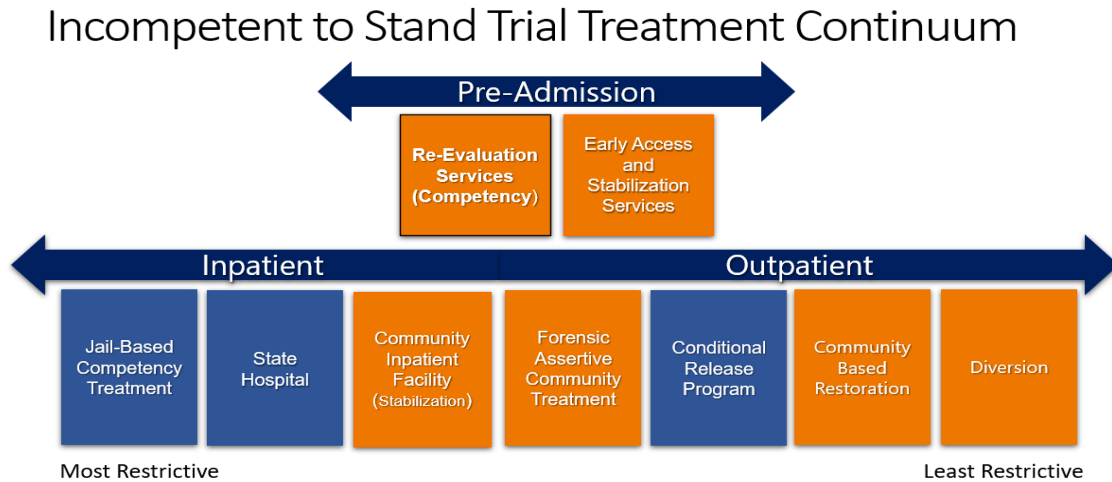
As DSH has expanded its continuum of care, the number of individuals found IST on felony charges and referred by the superior courts to DSH has continued to increase. During the COVID-19 pandemic, operational impacts slowed admissions and treatment capacity, further impacting the waitlist.

Prior to the declared State of Emergency, in February 2020, DSH had 850 individuals pending placement into a DSH IST treatment program. Throughout the pandemic, DSH observed seasonal fluctuations in the waitlist, with increases in winter and summer, and decreases in the spring and fall, as DSH recovered from COVID-19

surges. In January 2022, resulting from a COVID-19 surge, the IST waitlist reached a high of 1,953. In the 2023-24 May Revision, DSH reported the waitlist had declined to 804, inclusive of individuals receiving Early Access and Stabilization Services (EASS), which represented a reduction of 45 percent from the total waitlist of 1,473 reflected in the 2023-24 Governor's Budget.

IST Treatment Continuum

The following chart depicts the comprehensive continuum of IST services DSH has established and is continuing to build with the recent Budget Act investments. Blue boxes indicate DSH legacy programs which have been part of DSH's continuum for a decade or more, while orange boxes represent newer service options which began implementation in recent years.



Historically, restoration treatment options for individuals deemed IST on felony charges were provided in state hospitals, and over the last decade, in JBCT programs. Beginning in 2018, DSH expanded its continuum to include the pilot Felony Mental Health Diversion (Diversion) and partnered with Los Angeles (LA) County to establish the first felony IST community-based restoration program. More recently, in 2021, additional investments were made to expand the continuum of IST services with the implementation of pre-admission programs including IST re-evaluation services, early access and stabilization, and the establishment of additional levels of care and treatment settings to broaden the placement options available for all IST individuals. The information below describes the relevant programs within the IST treatment continuum addressed by this estimate.

IST Re-Evaluation Services

The Budget Act of 2021 authorized DSH to implement the IST Re-Evaluation Services Program as a 4-year limited-term solution to help address the IST waitlist. Under this program, DSH Consulting Psychologists re-evaluate individuals who have been deemed IST pending transfer to a DSH treatment program. By performing these Re-

Evaluations, DSH reduces the IST waitlist by identifying individuals who have already been restored to competency while receiving treatment in jail, or by identifying individuals who may be candidates for Diversion or other outpatient treatment programs. The evaluations also identify individuals who may be candidates for involuntary medication orders (IMOs), those who may warrant an acuity review, and those who may be unlikely to restore.

Since its inception, the IST Re-Evaluation Program has successfully implemented re-evaluation services in all eligible jails[3]. In addition to the re-evaluations, this team provides competency evaluations for newly emerging community IST treatment programs that currently do not or will not have forensic evaluator capacity available. DSH plans to deploy forensic evaluation resources flexibly and strategically to areas of IST forensic evaluation need as they become evident. In the 2023-24 May Revision, DSH reported a total of 2,407 evaluations had been completed since program inception, with more than 740 individuals found competent, returned to court, and removed from the IST waitlist due to Re-Evaluation Services.

Early Access and Stabilization Services (EASS)

The EASS program was established in FY 2022-23 as part of IST Solutions to provide treatment and stabilization to individuals deemed IST on felony charges in jail, pending placement into a bed in the IST treatment continuum. EASS seeks to increase community-based treatment placements by facilitating IST patients' stabilization and medication compliance, increasing eligibility for placement into a Diversion or other community-based treatment programs. In the 2023-24 May Revision, DSH reported the activation of three additional EASS counties programs, bringing the total number of operating EASS programs to 30.

Jail-Based Competency Treatment (JBCT)

DSH contracts with California county sheriffs' departments to provide restoration of competency treatment services to lower acuity patients committed as IST while they are housed in county jail facilities using one of the following four JBCT program models:

1. Single-county model – Serves IST patients from one specific county with an established number of dedicated program beds
2. Regional model - Serves IST patients from surrounding counties with an established number of dedicated program beds
3. Statewide model - Serves IST patients from multiple counties statewide with an established number of dedicated program beds
4. Small-county model – Services are delivered individually to a small number of IST patients, generally 12 to 15 annually, and do not have dedicated treatment beds

[3] Two counties (Alpine and Sierra) do not house IST patients.

Providing lower acuity patients with restoration of competency services, generally within 90 days, JBCT programs provide local treatment to individuals deemed IST. IST patients unable to quickly restore to trial competency can be subsequently referred to a state hospital for longer-term IST treatment. As DSH continued to expand and activate JBCT in additional counties, the 2023-24 May Revision reported the operation of 422 JBCT beds across 24 counties with plans for further expansions throughout the year.

Community Inpatient Facilities (CIF)

Originally introduced under the title "Institute for Mental Disease (IMD) and Sub-Acute Bed Capacity program", the CIF program authorized DSH to contract with counties or private providers to develop new, or renovate existing, community inpatient facilities to provide alternative treatment options to state hospitals, including IMDs, Mental Health Rehabilitation Centers (MHRCs), Skilled Nursing Facilities (SNFs), and other types of facilities appropriate for felony IST patients. With the objective of supporting county-operated community-based IST treatment programs where higher levels of care and/or security may be needed, individuals transitioning from jail are able to stabilize prior to stepping up, or down, into a treatment setting with different restrictions.

DSH activated its first 78-bed facility in Sacramento County in April 2022 at the Sacramento Behavioral Health Hospital (SBHH). As an acute psychiatric hospital, SBHH facilitates psychiatric stabilization of felony IST patients, primarily through administering medications to support restoration of competency, or via pathways to participation in Diversion or other outpatient treatment programs. In the 2023-24 May Revision, DSH reported negotiations were underway to establish new CIF locations with three additional facilities across the state.

Expanding Felony IST Community Programing via Community-Based Restoration (CBR) and Mental Health Diversion (Diversion)

The Budget Act of 2022 provided one-time infrastructure funding in FY 2022-23 and FY 2023-24 to develop residential housing settings to support felony IST individuals participating in either CBR or felony Diversion programs. Expansions of the CBR and Diversion programs aim to provide care in the most appropriate community-based setting as an alternative to placement in a DSH inpatient bed and used an estimation that 60-70% of annual IST commitments would be eligible for services in a community-based program. In FY 2022-23, DSH began to develop community-based capacity for a total of approximately 3,000 annual felony IST admissions, expanding the number of available patient beds through a CBR or Diversion program over a 4-year period[4].

[4] Dependent upon securing available housing.

In the 2023-24 May Revision, DSH reported collaborations had begun with the Advocates for Human Potential (AHP), a public service consulting firm, to provide ongoing project management for the creation of a 5,000-bed residential infrastructure. DSH and AHP developed and launched a website to manage the application process of any counties interested in submitting a request for proposal (RFP) for the residential housing development initial funding.

CBR and Diversion[5] Program Implementation

CBR and Diversion programs are community-based IST treatment options provided in the least restrictive, typically residential, settings. Access to locked acute and sub-acute settings may also be offered in response to the acuity needs of the individuals. Both programs offer intensive mental health treatment services with wraparound supports and housing.

The primary goal of CBR is restoration of competency and to that end, competency education is offered in addition to traditional mental treatment and supports. DSH can contract directly with counties or private providers to establish CBR programs statewide and implemented the first CBR program for felony ISTs in FY 2018-19 in partnership with the LA County Office of Diversion and Re-entry.

The DSH Diversion program has been designed to target a portion of the IST population most likely to succeed in an outpatient setting when provided the appropriate treatment, supports, and housing. Established as a pilot in the Budget Act of 2018, and in partnership with 29 counties, the Diversion program serves individuals with SMI diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with the potential to be found IST or determined IST on felony charges. Individuals who are successful in Diversion may have their charges dropped at the completion of the Diversion program. The Budget Act of 2022 allocated ongoing funding to establish Diversion as a permanent program which has been modified to serve only those who are determined to be IST across an expanded list of qualifying diagnoses.

As of the 2023-24 May Revision, DSH continued work with LA County to expand its existing CBR and Diversion programs and partnered with a private provider for a CBR program in Northern California to serve IST patients in surrounding counties, in a 16-bed MHRC facility with a planned activation of July 2023. Specific to Diversion, DSH reported the development of a county outreach plan and finalization of the

[5] Permanent Diversion program updates will be included in this proposal as part of IST Solutions, while data gathered and analyzed from the pilot will continue to be reported under the Diversion pilot narrative (Section D6) until its conclusion in FY 2024-25, as DSH works to transition counties already participating in the Diversion pilot into new agreements following completion of their pilot program contracts.

programmatic, funding, and contractual requirements for permanent program participation were underway.

County Stakeholder Workgroup Grants to Support IST Community Programs

In support of expanding IST community programming, DSH was allocated resources to aid behavioral health and criminal justice workgroups across the state, tasked with developing interventions in their communities to reduce the overall number of residents with SMIs who enter the criminal justice system, many of whom may be found IST on felony charges, with a focus on improving outcomes of those with a SMI who have fallen into cycles of incarceration and homelessness. Information about this opportunity was originally released to the counties on December 5, 2022, and in the 2023-24 May Revision, DSH reported 32 counties had submitted Letters of Intent (LOI) to contract with DSH for these annual resources. All interested counties were sent draft contracts with a planned activation date of July 1, 2023, and DSH planned to reopen the application process in the summer of 2023 for any counties unable to participate in the 2022 process.

Care Coordination & Waitlist Management

The Patient Management Unit (PMU) centralized patient pre-admission processes in June 2017 to ensure the placement of patients in the most appropriate setting based on clinical and safety needs. Prior to this, courts could order commitments to any DSH hospital, creating admission backlogs and inefficiencies.

The Budget Act of 2022 implemented a vertical case management model for IST patient placement, using small teams comprised of clinical and analytical staff dedicated to specific counties, with the goal of building relationships with county stakeholders and using a patient-centered approach to place patients in the most appropriate level of care based on bed availability. Under this new model, PMU clinical staff complete patient intake upon receipt of commitment. Along with clinical and medical intakes[6], placement decisions are based on patient eligibility, charging, medical exclusions, and each individual's position on the waitlist, in addition to availability of DSH placement options in the hospitals and outpatient programs (i.e., EASS, Diversion, and CBR).

In the 2023-24 May Revision, DSH reported a new monthly average of 488 referrals were received in FY 2022-23; an 18 percent increase from prior year. The Budget Act of 2023 authorized 5.0 positions using IST Solutions savings to support Care Coordination teams with increased referrals.

[6] Penal Code (PC) 1370 requires the courts and county sheriffs to remit health record information, commitment orders, and other relevant documents as specified for each IST committed to DSH to the PMU to facilitate admission.

Independent Placement Panel (IPP)

The Budget Act of 2022 included resources to pilot a new Independent Placement-Determination Panel (IPP), which sought to increase participation in the Conditional Release Program (CONREP) by individuals found Not Guilty by Reason of Insanity (NGI) or Offenders with a Mental Health Disorder (OMD), thereby increasing state hospital bed capacity for those on the IST waitlist.

In November 2022, DSH formed a stakeholder workgroup consisting of several county CONREP Community Program Directors (CPDs), DSH CONREP clinical staff, and state hospital discharge-planning teams to develop the IPP and establish an implementation plan, with a specific focus on determining assessment and referral protocols, justice partner engagement, CONREP program training, technical assistance, and streamlining the referral process and patient records database. In December 2022, DSH held an information session for all CONREP Community Program Directors (CPDs), leading to the finalization of all CONREP programs designated for phase one implementation (see below):

- Gateways – LA CONREP
- Orange County CONREP
- Harper Medical Group – Central Valley CONREP
    - Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Lassen, Mariposa, Merced, Modoc, Nevada, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, Tuolumne, Yolo
- Harper Medical Group – South Bay CONREP
    - Monterey, San Benito, Santa Clara, Santa Cruz
- MHM – Central California CONREP
    - Fresno, Kings, Madera, Tulare
- Kern CONREP
    - Kern, Inyo, Mono

In the 2023-24 May Revision, DSH reported IPP team members had visited all phase one counties to gain a better understanding of each facility's operations and were finalizing standardized evaluation and discharge processes to develop operational and procedural manuals.

Discharge Planning and Coordination with Counties

DSH undertakes comprehensive discharge planning to support continued patient success when releasing patients from a DSH facility, be it into the community with or without supervision, via transfer to other DSH facilities, or return to court, prison, or jail. Discharge efforts are myriad, including developing treatment goals and objectives with interdisciplinary treatment teams and patients, coordinating community

resources (including family and social supports), and partnering with local stakeholders and agencies for further treatment options. Local treatment stakeholders coordinate with DSH to obtain IST patient information in preparation for return to their county, including but not limited to the following[7]:

- CONREP
- County Behavioral Health
- County jails
- Other inpatient or subacute facilities
- Board and Care facilities
- Office of the Public Guardian
- Private conservators
- California Department of Corrections and Rehabilitation (CDCR)

To establish a standardized packet of discharge documents and facilitate a warm handoff of IST patients to their transition location from a state hospital, DSH held a workgroup session in August 2022, with representatives from the County Behavioral Health Directors Association of California (CBHDA) and California State Association of Counties (CSAC).

In the 2023-24 May Revision, DSH reported this workgroup had produced a comprehensive CONREP Discharge Referral handbook of these processes to be implemented by Discharge and Community Integration (DCI) specialists present at each state hospital.

Alienist Training

Through a partnership formed with the Judicial Council in 2022, DSH sought to develop statewide court-appointed IST evaluator training and workforce development programs, with the objective of improving the quality of IST evaluations performed by court-appointed evaluators. These forensic evaluations determine defendant competency status and serve as the basis for IST commitment to DSH.

In the 2023-24 May Revision, DSH reported an interagency agreement with the Judicial Council had been executed in December 2022, with a consulting group contract planned for completion in Spring 2023. The Judicial Council planned to analyze existing report quality to inform specific training needs for the IST forensic evaluators program, targeting any gaps in report quality.

Felony IST Referral Growth Cap and Penalties

To address the growing IST waitlist, the Budget Act of 2022 enacted WIC section 4336 to establish a growth cap on the number of annual felony IST determinations per

[7] Individuals may also be diverted from jail because of dropped or reduced charges and provided supervised release back to the community.

county, and implemented a re-direction of county funds to be assessed if annual caps are exceeded.

In the 2023-24 May Revision, DSH reported it had released the first quarterly update to the counties in February 2023, including each county's total unreconciled IST determinations through the second quarter of the fiscal year. The results of FY 2022-23 data displayed an increasing trend in IST determinations. In FY 2021-22, the monthly average number of IST determinations was 356.8. As of the second quarter update, the FY 2022-23 monthly average number of IST determinations was approximately 500. Per the data used for this update, 41 counties had an increased monthly average IST determination rate and were trending towards exceeding their IST determination baseline in FY 2022-23.

Placement Presumption

The Budget Act of 2022 amended PC Section 1370 to statutorily prioritize community outpatient treatment effective July 1, 2023[8], increasing consideration for placement of IST patients in Diversion, CBR, or other community IST facilities. In the 2023-24 May Revision, DSH reported CONREP CPDs completed training in March 2023, emphasizing recommendations for Diversion consideration.

IST Solutions Budget Act of 2023

In response to the 21 percent increase in IST referrals, in the Budget Act of 2023, DSH received 6.0 positions to provide case coordination to this increased caseload in FY 2023-24, while reporting a net savings of $3.1 million in FY 2023-24 and ongoing due to changes in the JBCT program implementation efforts.

DSH also received approval to reappropriate up to $107 million from the Budget Act of 2022 to reflect updates in implementation across all IST programs, including CIFs, CBR, Diversion, EASS and JBCT, as well as approval to reappropriate up to $100 million of from the Budget Act of 2021 to reflect additional time needed for the CIF infrastructure projects. Lastly, DSH received approval for $129.5 million to be diverted from the Budget Act of 2021 to FY 2025-26 to better capture anticipated expenditures based on program implementations.

[8] Unless a court, based on the recommendation of the Community Program Director or designee, finds the clinical needs or community safety risk warrants placement in a more secure setting, such as a state hospital or JBCT program.

JUSTIFICATION

IST Waitlist

In the 2023-24 May Revision, DSH reported the IST waitlist had declined to 804 due to the implementation and expansion of existing IST programs. As of the 2024-25 Governor's Budget, the IST waitlist is currently at 501[9]. This change represents a reduction of 38 percent from the total waitlist reported in the 2023-24 May Revision. Furthermore, of the 501 individuals on the waitlist pending admission to a treatment bed, 172 are receiving substantive treatment services through EASS or other treatment program. Only 329 individuals on the waitlist are individuals who are not yet receiving treatment services from a DSH program.

IST Re-Evaluation Services

In the 2023-24 May Revision, DSH reported a total of 2,407 completed evaluations, of which:

- 1,658 (69%) were found not competent and continued competency restoration treatment
- 742 (31%) were found restored to competency
- <11[10] (<1.0%) were found unlikely to be restored to competency

As of November 24, 2023, DSH has completed 4,817 evaluations, of which:

- 3,273 (68%) were found not competent and continued competency restoration treatment
- 1,518 (32%) were found restored to competency
- 26 (<1.0%) were found unlikely to be restored to competency

For individuals found competent following re-evaluation services, DSH has submitted reports to the court regarding restored competency status, allowing those individuals to continue their court proceedings and be removed from the waitlist. Through earlier identification of individuals who are competent, and enabling court proceedings to resume, wait times for individuals still requiring treatment have significantly reduced. Re-evaluation reports also allow the courts to consider different treatment options. The services provided identified approximately 20 percent of participants as needing IMOs, and approximately 55 percent as being potentially eligible for Diversion.

With progress in meeting *Stiavetti* substantive treatment timelines and the expansion of EASS in county jails and community-based programs, the demand for in-jail re-

[9] Data as of January 1, 2024.
[10] Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines, with values of 11 or less represented as "<11".

evaluation has slowed. As such, DSH is repurposing IST Re-Evaluation resources to meet increasing demand for IST evaluations in an array of DSH programs. This repurposing accelerates admissions and discharges, which reduces wait times and increases access to care. DSH plans to deploy these forensic evaluation resources flexibly and strategically to all areas of IST forensic evaluation need as they become evident. DSH will continue to monitor IST forensic evaluation needs and provide an update in the 2024-25 May Revision.

Early Access and Stabilization Services (EASS)

In the 2023-24 May Revision, DSH reported the successful activation of 30 EASS programs, with additional activations planned across the state. In the 2024-25 Governor's Budget, DSH has activated an additional 14 county programs, bringing the total amount of EASS programs to 44 as of November 29, 2023. The following table displays all counties with EASS programs and their activation dates.

Early Access and Stabilization Services (EASS) Updates	
County	**Activation Date**
San Mateo	10/23/23
Yolo	10/18/23
Tehama	10/18/23
San Joaquin	10/16/23
Butte	09/27/23
Inyo	09/15/23
Sacramento	09/01/23
San Luis Obispo	08/23/23
San Diego	08/16/23
Modoc	06/01/23
Mono	04/19/23
Tulare	04/17/23
Colusa	04/12/23
Mariposa	04/01/23
Glenn	03/29/23
El Dorado	02/21/23
Solano	02/01/23
Plumas	01/12/23
Amador	12/19/22
Tuolumne	12/14/22
Lake	12/07/22

San Benito	12/07/22
Riverside	12/05/22
Sutter	12/01/22
Napa	11/16/22
Santa Cruz	11/09/22
Imperial	10/26/22
Del Norte	10/19/22
Humboldt	10/19/22
Lassen	10/17/22
Sonoma	10/17/22
Madera	10/06/22
San Bernadino	09/26/22
Merced	09/19/22
Santa Barbara	09/16/22
Shasta	09/12/22
Nevada	08/31/22
Sierra	08/31/22
Stanislaus	08/29/22
Yuba	08/29/22
Calaveras	08/25/22
Fresno	08/22/22
Ventura	08/03/22
Monterey	07/25/22
Kings	07/18/22

As of the 2024-25 Governor's Budget[11], DSH reports the following updates for EASS programs:

- Total patients served: 2,380
- Total patients unenrolled[12]: 2,184
- Total restored while in EASS: 415(19.0% of those who received services)

[11] Data as of November 15, 2023.

[12] Unenrolled refers to patients no longer receiving EASS services due to competency reached or transfer to a DSH program to continue IST treatment services. Patients who are not restored maintain their place on the waitlist and are admitted to a DSH facility in accordance with their commitment date.

DSH continues to pursue standalone EASS county models for those counties preferring to use their county behavioral staff or currently contracted providers; however, operational costs for standalone EASS county models are significantly higher than EASS Programs operated by DSH's contracted clinical providers. As of the 2024-25 Governor's Budget, DSH has executed contracts for two standalone EASS counties with programs activated and is in contract negotiations with four standalone county programs. DSH anticipates two programs to activate in winter 2023, with the remainder to activate in spring 2024.

Despite the rapid activation of EASS programs across the state, several large county programs anticipated for activation in current year have been delayed, resulting in an estimated $20 million in one-time savings in FY 2023-24 for the program. DSH will continue to monitor implementation timelines and assess whether current ongoing funding levels are sufficient to support EASS programs in all other counties and provide an update in the 2024-25 May Revision.

Jail-Based Competency Treatment (JBCT)

As of the 2024-25 Governor's Budget, DSH continues its efforts to expand the JBCT program and reports the operation of 424 JBCT beds across 24 counties and reflects a one-time net savings of $8.6 million in FY 2023-24. The following are updates to the program since the 2023-24 May Revision. Recent program activity includes:

- Delays in expansions for three counties and five counties pending activations
- Funding redirected from two counties pending activation to support an expansion for two other counties (Riverside, Tulare)
- Request for a new 18-bed program in Northern CA County O
- Increasing bed rates are anticipated in several participating counties

Activation of these programs has been significantly delayed due to the COVID-19 pandemic, as well as additional operational and staffing challenges. Attachment A details all JBCT program updates, including total capacity and bed rate increases.

While DSH reflects a one-time net savings at Governor's Budget, the Department will continue to work with counties across the state to expand or activate new JBCT programs. The Department will provide an update on program activity, and any future fiscal asks, in the 2024-25 May Revision.

Community Inpatient Facilities (CIF)

DSH activated two new contracted CIF programs in southern California for the treatment of the felony IST population on July 3, 2023. On July 6, 2023, Bakersfield Behavioral Healthcare Hospital (BBHH) admitted its first patient to a 29-bed acute inpatient psychiatric facility in Kern County. On July 7, 2023, Anaheim Community

Hospital (ACH), a 36-bed acute inpatient psychiatric facility in Orange County, admitted its first patient.

Additionally, DSH has contracted with two facilities to provide full competency restoration services. The first location, Priorities, Inc., activated on July 3, 2023, and is a 16-bed MHRC located in Sutter County. The second contract is with Sylmar Health and Rehabilitation Center, Inc. in Los Angeles County. DSH transitioned a 24-bed unit at this location from a CONREP treatment program to an IST treatment program (the current CONREP clients were transferred to the new Golden Legacy IMD in October 2023). DSH activated this unit for IST patients in October 2023.

The following table shows DSH's activated CIF programs and total beds available in each program:

Activated Community Inpatient Facilities			
Facility Name	**Activation Date**	**Total Beds**	**Census as of 11/27/23**
BBHC	7/3/2023	29	29
ACH	7/3/2023	36	27
Priorities, Inc.	7/3/2023	16	15
SBHH	4/20/2022	78	65

DSH has also executed a construction contract with Crestwood Behavioral Health, Inc. for the development of a 36-40-bed MHRC located in Fresno County. The project will remodel an existing building, and activation of the program is expected in early fall 2024. While the Department continues negotiations with multiple providers interested in partnering with the department to develop new CIFs across the state and continues to seek new potential projects, DSH anticipates a one-time current year savings of $30 million due to the lengthy negotiation process required to secure the additional contracts in time for a FY 2023-24 program activation. DSH will provide an update in the 2024-25 May Revision.

<u>Expanding Felony IST Community Programing via Community Based Restoration (CBR) and Diversion</u>

DSH was allocated one-time infrastructure funding to expand the number of beds available to patients receiving services through a CBR or Diversion program and support the creation of statewide residential beds to house IST patients. In June 2023 DSH executed a contract with the Advocates for Human Potential (AHP) public consulting firm, and in March 2023, an application portal was opened for counties to submit their requests for proposals (RFPs) for the funding to develop residential housing. To accompany the portal, AHP developed a website which included responses to frequently asked questions, as well as AHP's contact for further information assistance.

In October 2022, January 2023, and June 2023, DSH and AHP hosted three webinars to inform county stakeholders applications would be accepted on a rolling basis through June 30, 2024. As of November 2023, four counties have submitted proposals to AHP, and contract negotiations are underway to develop up to 412 beds to house felony IST defendants participating in Diversion or CBR programs. Additionally, as of November 2023, 26 counties have expressed interest in submitting applications in the future.

AHP has implemented a robust communication plan to reach all counties, respond to questions, remind counties of the funding opportunity, and encourage counties to apply. Counties accepting funding from AHP for this project are required to contract with DSH for a Diversion or CBR program (or both). DSH will provide an update on continued progress in the 2024-25 May Revision.

Los Angeles County CBR and Diversion Program

DSH and the Los Angeles County Office of Diversion and Re-entry executed a contract in summer 2023 to significantly expand the county's CBR and Diversion program. The new agreement with LA County will expand the program from 515 beds previously designated for its CBR up to a total of 1,344 beds, to be phased in over a 5-year period. The beds will be established at various locations throughout the county across a continuum of settings, including a locked acute psychiatric hospital, a locked IMD or MHRC, and residential facilities with onsite clinical and supportive services. At full activation of all beds, the program will admit up to 840 new (unique) felony IST patients per year in addition to patients residing in beds who may have been admitted in the prior year. The following table shows LA County CBR and Diversion program census from October 2022 through November 2023 and total patients served.

LA County Program	10/31/22 Census	Admissions (11/1/22 – 11/6/23)	Total Patients Served
CBR	450	186	636
Diversion	159	301	460

As of October 30, 2023, LA County has 285 ISTs enrolled in CBR and 335 in Diversion. LA County anticipates it will activate 200 new beds in FY 2023-24, bringing the total beds available in LA County to 825 which will support up to 572 new IST admissions over the course of the year.

Other Permanent Diversion and CBR Program Implementation

As of the 2024-25 Governor's Budget, DSH has partnered with Capstone Solutions Consulting Group to advise DSH on the development of the permanent statewide

program structure and assist DSH with better understanding the position of counties in the development of these programs. Capstone will also serve as a liaison between DSH and counties interested in participating in the permanent program.

On November 9, 2023, DSH informed stakeholders of the permanent program requirements at a Diversion Quarterly County meeting. Counties were provided with fiscal details during this webinar, including information about funding for wraparound treatment services, county overhead costs, risk assessments, court liaison positions, justice partners, and other funding. Counties were also informed of new Diversion and CBR statutory and program requirements and recommendations, and the process and timelines for reporting data to DSH.

A variety of resources were shared with counties during the webinar, including information about three CIFs for ISTs, the DSH IST Re-Evaluation Team which may re-evaluate ISTs in CBR programs, the Advocates for Human Potential (AHP) grant opportunity and the process for applying for the permanent infrastructure funding through June 2024, the Psychopharmacology Resource Network (PRN), and the DSH Diversion and CBR team of psychologists and program staff assigned to each county once a Letter of Intent (LOI) is submitted to DSH and the county enters into a contract with the Department.

County Stakeholder Workgroup Grants

In December 2022, DSH released information to counties about supporting behavioral health and criminal justice workgroups by offering annual resources. A total of 32 counties submitted Letters of Intent (LOI) to enter into contracts with DSH. As of November 2023, 29 of the 32 counties have executed contracts with DSH while the remaining three contracts are in the process of being executed. Information was re-released by DSH to the counties again on June 30, 2023, to provide another opportunity for counties to apply. Interested counties can submit an LOI by September 1, 2023, to enter into a contract effective January 1, 2024, or submit an LOI by December 1, 2023, to enter into a contract with an effective date of July 1, 2024. The 32 counties contracting with DSH for the stakeholder workgroup grants are listed below:

- Butte
- Contra Costa
- Del Norte
- Fresno
- Kern
- Madera
- Mendocino
- Merced
- Mono
- Monterey
- Nevada
- Riverside
- Sacramento
- San Bernardino
- San Diego
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbra
- Santa Clara
- Santa Cruz
- Shasta
- Siskiyou
- Solano
- Sonoma
- Stanislaus
- Sutter

- Tulare
- Tuolumne
- Ventura
- Yolo
- Yuba

DSH will provide an update on new county participation in the 2024-25 May Revision.

Care Coordination & Waitlist Management

As of the 2024-25 Governor's Budget, DSH can report Care Coordination has been implemented to serve all 58 counties. In addition to implementing a patient-centered approach to patient placement, for counties with an active EASS program, PMU clinicians are actively liaising with EASS care providers to provide active case management. PMU also convenes a weekly workgroup with stakeholders in LA County to address challenges specific to that county. The LA Care Coordination team has centralized not only pre-admission processing, but transportation scheduling to better troubleshoot issues with county partners. This approach has significantly reduced missed admissions from LA County, lowering wait times and decreasing the number of individuals pending placement specifically from LA County.

In addition to county focused teams, the PMU facilitates and assists with coordinating re-evaluations and schedules transportation to and from all CIFs. DSH will continue to monitor the Care Coordination program activity and provide an update in the 2024-25 May Revision.

Independent Placement Panel (IPP)

The IPP policies and procedures manual was completed and finalized in June 2023 and implementation of the IPP began on July 1, 2023. As of the 2024-25 Governor's Budget, IPP received a total of 33 referrals, of which 26 had completed evaluations submitted to the courts. DSH will provide an update on the number of total evaluations conducted in the 2024-25 May Revision.

Discharge Planning and Coordination with Counties

In 2022, a series of meetings were held with County Behavioral Health Directors Association (CBHDA) and California State Association of Counties (CSAC) representatives to discuss establishing a standard IST discharge packet to support pre-trial service provisions, as well as continuity of care and coordination. Over the course of these meetings, Subject Matter Experts (SMEs) representing all stakeholders agreed upon the vital patient information necessary to support these efforts. DSH is presently working to standardize the agreed upon forms across all facilities. Additionally, DSH is actively working to operationalize the sharing of the documents to include identifying a secure HIPPA compliant transmittal process.

To enhance the CONREP Discharge Referral process, a comprehensive four volume training series was created and is now pending approval for publishing to all DSH staff via the DSH online training portal (DSHLearns). Discharge and Community Integration (DCI) Specialists are currently providing discipline-specific discharge referral process trainings across all hospitals and serve as points of contact for questions and problem-solving for identified barriers to the successful implementation of the standardized CONREP referral process. An update will be provided in the 2024-25 May Revision.

Alienist Training

In June 2023, the Judicial Council contracted with the Groundswell Group to develop statewide court-appointed IST evaluator training and workforce development programs, with the objective of improving the quality of IST evaluations performed by court-appointed evaluators. The contractor is currently conducting an analysis to develop training materials and will conduct a pilot utilizing these materials in November 2023. An update to the pilot training and additional training goals with be provided in the 2024-25 May Revision.

Felony IST Growth Cap Referrals and Penalties

As of the 2024-25 Governor's Budget, DSH requests 2.0 Research Data Specialist (RDS) Is (position authority only) to successfully administer the Felony IST Growth Cap program.

Program Update

After release of departmental guidance regarding the growth cap and initial IST determination data to counties in December 2022, a significant number of issues were raised by counties in the areas of: 1) the methodology utilized by DSH to identify the total number of county IST determinations and providing detailed data for counties to reconcile court records; 2) establishing a dispute process to allow counties to correct IST records; and 3) acknowledging the counties' participation in operating IST treatment programs.

In May 2023, DSH began engaging in discussions with a coalition of county associations, representing key IST stakeholders, to consider updates to the methodology for the IST Growth Cap program. On August 1, 2023, DSH released updates to the methodology and rate for the growth cap and implemented a dispute process for potential data discrepancies. New data for FY 2021-22 baseline calculations and unreconciled FY 2022-23 IST determinations were provided to the counties with release of the August 1 notification. Further, DSH has implemented a process to issue quarterly IST data reports to allow counties to monitor their IST determinations trends compared to their baseline, and take action if necessary to

avoid charged fees as a result of IST determinations exceeding the established growth cap. In addition, DSH has solicited county designated representatives who are authorized to receive confidential individualized IST commitment data and is releasing this detailed data to those representatives at quarterly intervals to assist with county level referral tracking.

On October 5, 2023, DSH released reconciled FY 2022-23 IST Growth Cap data to counties which commenced the timeframe for counties to review their data, compare to their FY 2021-22 baseline count of IST determinations, and submit any disputes to DSH prior to the dispute window closing in January 2024. Based on the current Growth Cap data, excluding potential adjustments that could result from a dispute, 11 counties may be assessed fees ranging from $34,500 to $13.6 million, for a total value of $26.1 million. After the dispute resolution process, DSH anticipates sending final invoices to counties in spring 2024. Once collected, this funding will ultimately be distributed back to the counties to support targeted strategies aimed at reducing growth in the number of IST determinations, following the counties' submittal of a spending plan for the funds.

Position Justification to Support Growth Cap Workload

The magnitude of workload to support the Felony IST Growth Cap programs was not contemplated at the time of the initial development of the IST Solutions Budget package. This program requires ongoing reconciliation of IST determinations and waitlist data for each county. This time-intensive task involves the weekly review of every IST determination referred to DSH to accurately compile quarterly progress reports and establish annualized data used to calculate potential penalty fees assessed for each county. Another significant workload driver is related to the dispute process which requires manual validation of individual IST commitment orders for disputed records, fielding questions from counties, and outreach and coordination with the court to investigate disputed IST documents. As an example, DSH received a dispute from one county with 91 IST determinations and claimed that 19 IST determinations were not counted in their 2021-22 baseline total. The validation process to respond to this dispute took approximately 72 hours, including but not limited to, time spent on outreach to the county, coordinating missing information required to validate the data, manually looking up patient information across multiple DSH systems, and researching legal documents. To address this immediate need DSH requests permanent position authority only to establish 2.0 Research Data Specialist (RDS I) positions to administer the Felony IST Growth Cap program.

DSH will provide additional updates in the 2024-25 May Revision.

Resource Table[13]

Description	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	Ongoing
IST Solutions Current Service Level[14]	$75,000	$382,316	$543,128	$471,739	$591,933	$591,933
JBCT Current Service Level	$82,834	$92,573	$118,217	$120,353	$120,353	$120,353
CBR Current Service Level	$48,383	$78,358	$74,983	$73,483	$73,483	$73,483
Community Inpatient Facilities Current Service Level	$137,609	$92,540	$246,006	$145,526	$274,999	$145,526
Re-Evaluation Current Service Level[15]	$13,729	$12,000	$10,176	$10,176	$1,000	$1,000
Governor's Budget Request[16]	$0	$0	($58,573)	$0	$0	$0
TOTAL	$357,555	$657,787	$933,937	$821,277	$1,061,768	$932,295

[13] Dollars in thousands.
[14] FY 2022-23 One-time of $328,750,000; FY 2023-24 One-time of $160,000,000; FY 2024-25 One-time of $5,000,000.
[15] Pilot program ends June 30, 2025, however, DSH is currently evaluating the ongoing need for this program.
[16] Governor's Budget Request includes savings $20,000,000 from EASS; $8,573,000 from JBCT; $30,000,000 from CIF.

Attachment A

Total JBCT Capacity and Projected Funding									
Existing JBCT Capacity and Projected Funding									
Program	**Bed Capacity in FY 2023-24**	**Bed Capacity in FY 2024-25**	**FY 23-24 MR Activation/ Expansion**	**FY 24-25 GB Activation/ Expansion**	**23-24 MR Per Diem Rate**	**24-25 GB Per Diem Rate**	**2023-24**	**2024-25**	**2025-26**
Butte JBCT	10	10	-	-	$441	$491	-	$121	$183
Calaveras JBCT	18	18	-	-	$478	$489	-	$68	$335
Humboldt	8	8	-	-	$519	$519	-	-	-
Kern AES	60	60	-	-	$480	$480	-	-	-
Kings JBCT	8	8	-	-	$520	$520	-	$44	$158
Mariposa JBCT	N/A	N/A	-	-	-	-	-	-	-
Mendocino JBCT	6	6	-	-	$420	$491	-	$155	$155
Merced JBCT	9	9	-	-	$550	$566	-	-	-
Monterey JBCT	13	13	Jul-23	Sep-23	$491	$491	($61)		
Placer JBCT	15	15	-	-	$441	$592	$829	$827	$827
Riverside JBCT	25	32	-	Jan-24	$422	$491	$939	$1,884	$1,884
Sacramento JBCT	44	44	-	-	$540	$562	-	-	-
San Bernardino JBCT	64	64	-	-	$626	$640	-	-	-
San Diego JBCT	30	40	Jul-23	Jul-24	$420	$491	($1,537)	$514	$1,037
San Joaquin JBCT	12	12	-	-	$424	$446	-		$197
San Luis Obispo JBCT	8	8	-	-	$486	$486	-	-	-

Santa Barbara JBCT	10	15	Jan-24	Jul-24	$491	$516	($447)	$137	$279
Shasta JBCT	8	8	-	-	$455	$474	-	-	-
Solano JBCT	12	14	Oct-23	Mar-24	$491	$491	($494)	($358)	($358)
Sonoma JBCT	14	14	-	-	$574	$574	-	-	-
Stanislaus JBCT	18	18	-	-	$490	$490	-	-	-
Tulare JBCT	15	30	-	Jan-24	$474	$489	$1,294	$2,677	$2,677
Ventura JBCT	10	10	-	-	$441	$491	-	$183	$183
Yolo JBCT	7	7	-	-	$516	$542	-	-	-
Northern CA County E	5	-	Jan-24	R/D	$491	$491	($447)	($896)	($896)
Northern CA County I	15	15	Oct-23	Sep-24	$570	$570	($2,343)	($530)	-
Northern CA County J	15	15	Jan-24	Sep-24	$491	$491	($1,340)	($457)	-
Central CA County K	7	-	Jan-24	R/D	$491	$491	($626)	($1,255)	($1,255)
Northern CA County N	19	19	Oct-23	Sep-24	$653	$653	($3,400)	($769)	-
Central CA County L	12	12	Jul-23	Dec-23	$512	$512	($940)	-	-
Southern CA County M	25	25	Jul-24	Sep-24	$534	$534	-	($828)	-
Existing Subtotal	**522**	**549**					**($8,573)**	**$1,517**	**$5,406**

New JBCT Capacity and Projected Funding									
Program	**Bed Capacity in FY 2023-24**	**Bed Capacity in FY 2024-25**	**FY 23-24 MR Activation/ Expansion**	**FY 24-25 GB Activation/ Expansion**	**23-24 MR Per Diem Rate**	**24-25 GB Per Diem Rate**	**2023-24**	**2024-25**	**2025-26**
Northern CA County O	-	18	-	Sep-24	-	$653	-	$3,561	$4,290
Patients' Rights Advocate Funding	N/A	N/A	N/A	N/A	N/A	N/A	-	$19	$19
New Subtotal	**0**	**18**					**$0**	**$3,580**	**$4,309**
TOTAL	**522**	**567**					**($8,573)**	**$5,097**	**$9,715**

STATE HOSPITALS
COUNTY BED BILLING REIMBURSEMENT AUTHORITY
Informational Only

SUMMARY

As of Governor's Budget, the Department of State Hospitals (DSH) does not project an adjustment to its current County Bed Billing Reimbursement Authority. An update will be provided in the 2024-25 May Revision.

BACKGROUND

The County Bed Billing Reimbursement Authority is comprised of two main components pertaining to county financial responsibility. These include billings for the Lanterman-Petris-Short (LPS) population and Non-Restorable (NR)/Maximum-Term (MT) Incompetent to Stand Trial (IST) defendants who are not timely transported by and returned to the committing county under specific statutory circumstances.

LPS Population

The LPS population includes civilly committed patients who have been admitted to DSH under the LPS Act (Welfare and Institutions Code (WIC) § 5000 et seq.). The LPS population is referred to DSH by county behavioral health organizations through involuntary civil commitment procedures pursuant to the LPS Act. WIC § 4330 requires counties to reimburse DSH for their use of hospital beds and services provided pursuant to the LPS Act.

IST Non-Restorable (NR) and IST Maximum Term (MT) Population

Pursuant to penal code (PC) §1370, when a state hospital issues a progress report stating there is no substantial likelihood a defendant will recover mental competence, the defendant shall be returned to the committing court, and custody of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. Pursuant to PC §1370 (b)(1) and §1370 (c)(1), if a county does not take custody of a defendant committed to DSH within 10 calendar days following notification, DSH is authorized to charge counties the daily rate for a state hospital bed. Assembly Bill 133 (Chapter 143, Statutes of 2021) authorizes DSH to charge a county the daily bed rate for each day that a defendant is not transported back to the county and remains in DSH custody.

In the Budget Act of 2023, DSH reduced the County Bed Billing Reimbursement Authority by $27.4 million in fiscal year (FY) 2023-24 and ongoing to align with the current LPS population census and increased bed rates.

JUSTIFICATION

As of the 2024-25 Governor's Budget, DSH assumes no adjustments to the current reimbursement authority for FY 2023-24 or FY 2024-25.

DSH is currently collaborating with the California Mental Health Services Authority (CalMHSA) to identify opportunities to improve county utilization of the 556 beds that DSH makes available to counties for treatment of the LPS population through a Memorandum of Understanding (MOU) with the counties. As of November 13, 2023, the county LPS census was 557 and exceeded the 556 beds contracted for in the MOU, and there are 352 patients who were referred by the counties on a waitlist for admission. Of the patients in the census, as of September 25, 2023, DSH had notified the county that 136 were ready to transition to a lower level of care and the counties had not yet discharged the patients.

DSH will continue to monitor and provide an update in the 2024-25 May Revision on population projections as well as its efforts with CalMHSA.

STATE HOSPITALS
MISSION-BASED REVIEW – COURT EVALUATIONS AND REPORTS
Informational Only

SUMMARY

As of the 2024-25 Governor's Budget, all positions approved for Court Evaluations and Reports have been completely phased in. The Department of State Hospitals (DSH) is conducting a thorough internal post implementation evaluation to identify all impacts to the Forensic Services workload resulting from the newly acquired positions.

BACKGROUND

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. As part of DSH's staffing study efforts, and in collaboration with the Department of Finance (DOF) Research and Analysis Unit through a Mission-Based Review, the process for completing all forensic services workload within each hospital's Forensic Services Department was examined. This examination involved review of all statutory language directing the commitment and treatment of patients, depiction of the forensic process (i.e., flow charts) from commitment to discharge for each commitment type, review of datasets available to document the throughput of the process and convening a multitude of subject matter expert interviews to document current practices and challenges. This in-depth review led to the proposed methodologies for staffing each component of Forensic Services.

The Budget Act of 2019 included 94.6 permanent full-time positions, phased-in over three (3) years, to implement the staffing standard to support the forensic services workload associated with court-directed patient treatment. The standard establishes population-driven methods for calculating staffing needs for the following forensic functions: Evaluations, Court Reports, and Testimony; Forensic Case Management and Data Tracking; and Neuropsychological Services (Neuropsychological Assessments and Cognitive Remediation Pilot Program).

In the Budget Act of 2021, recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing staff and patient exposure, delaying some position phase-ins.

PROGRAM UPDATE

Evaluations, Court Reports, and Testimony

A total of 53.1 positions were allocated to support forensic evaluations, court reports, and testimony, to be phased-in over four years.

As of August 31, 2023, all position phase-ins are complete.

Forensic Case Management and Data Tracking

A total of 16.3 positions were allocated to support forensic case management and data tracking, phased-in over three years.

As of August 31, 2023, all position phase-ins are complete.

Neuropsychological Services

A total of 25.2 positions were allocated to support neuropsychological services, phased-in over three years. This included 11.2 positions for conducting Neuropsychological Assessments and 14.0 positions in a Cognitive Remediation Pilot Program at DSH-Metropolitan and DSH-Napa

As of August 31, 2023, all position phase-ins are complete.

Cognitive Remediation Pilot Program

As of August 31, 2023, DSH-Napa[1] is serving five patients, and DSH-Metropolitan[2] is serving nine patients in the Cognitive Remediation Pilot Program. At DSH-Napa, four additional patients have been referred to this program, and DSH-Napa is in the process of establishing a new cohort, with a target date of January 2024. Cognitive Rehabilitation Program psychologists are developing an incentive program to motivate sustained engagement. They are also discussing lowering eligibility requirements with the statewide Cognitive Rehabilitation Program consultant.

Post Implementation Evaluation

DSH is conducting an internal Post Implementation Evaluation to assess all methodologies and data elements in the three forensic functions: Evaluations, Court Reports, and Testimony; Forensic Case Management and Data Tracking; and Neuropsychological Services. This evaluation includes identifying any changes in operations, forensic processes, and statutory requirements, and any impact to the

[1] DSH-Napa has served a total of 24 patients since implementation.
[2] DSH-Metropolitan has served a total of 33 patients since implementation.

forensic services workload. As of the 2024-25 Governor's Budget, all positions have been phased in and the Post Implementation Evaluation is in progress, therefore DSH has fulfilled the reporting requirements for this item.

STATE HOSPITALS
MISSION-BASED REVIEW – PROTECTIVE SERVICES
Informational Only

SUMMARY

As of the 2024-25 Governor's Budget, all positions authorized for Protective Services have been completely phased in. The Department of State Hospitals (DSH) is conducting an internal post implementation evaluation to identify all impacts to the Protective Services workload resulting from newly acquired positions.

BACKGROUND

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. As part of this assessment, the Clinical Staffing Study reviewed DSH Protective Services, focused on three key elements:

- Identification of staffing standards across all protective services operations
- Developing standardized methodologies for calculating staffing needs
- Identification of the appropriate relief factors to ensure sufficient coverage across all posts

DSH Protective Services encompasses all operations necessary for providing a secure and safe treatment environment for patients and a safe work environment for DSH employees. This service extends to operating a safe facility within the residing communities and ensuring safety to individuals entering the hospital grounds. As a law enforcement agency, DSH Protective Services provides 24-hour police services responsible for the safety of all hospital operations.

In the Budget Act of 2023, DSH reported $11.5 million in savings for fiscal year (FY) 2022-23 due to delays in hiring.

PROGRAM UPDATE

<u>Support and Operations Division</u>

A total of 98.1 positions were allocated to support the Support and Operations Division to be phased in over two years, which aligns with DSH Academy cohorts to maximize funding and recruitment.

As of August 31, 2023, all position phase-ins are complete.

Executive Leadership Structure

A total of 6.0 positions were allocated to support the Executive Leadership Structure in the beginning of FY 2021-22.

As of August 31, 2023, all position phase-ins are complete.

Post Implementation Evaluation

DSH is conducting an internal Post Implementation Evaluation of all data elements. This evaluation includes reviewing resources received to-date, determining the impacts of the COVID-19 pandemic, and assessing current HPO overtime rates. As of the 2024-25 Governor's Budget, all positions have been phased in and the Post Implementation is in progress.

STATE HOSPITALS
WORKFORCE DEVELOPMENT
Informational Only

SUMMARY

As of the 2024-25 Governor's Budget, the Department of State Hospitals (DSH) is cultivating educational partnerships, recruiting for the upcoming DSH-Napa residency cohort, and developing a new residency program at DSH-Patton. Additionally, DSH is negotiating agreements to expand psychiatric fellowships and resident rotation opportunities.

BACKGROUND

Historically, recruitment and retention have posed a challenge for DSH and have been further exacerbated during the COVID-19 pandemic. While DSH is not alone in its staffing challenge for healthcare workforce, DSH does present unique challenges for recruitment and retention due to multiple factors. The individuals DSH serves have some of the most difficult to treat behavioral health conditions, many with a significant violence risk level. This, coupled with the geographic locations of DSH facilities and nationwide shortages for the healthcare workforce DSH employs, makes recruitment and retention challenging. Due to these factors, DSH has implemented a multi-faceted approach in an effort to recruit and retain staff.

<u>Psychiatric Technician (PT) Programs</u>

The Budget Act of 2019 included ongoing resources to work in conjunction with the Mission-Based Review – Direct Care Nursing proposal to attract and retain a sufficient workforce of trained medical professionals. While nursing level of care classifications vary at DSH, this initiative was focused primarily on recruitment for registered nurses (RNs) and psychiatric technicians (PTs). These two nursing classifications reflect most of the authorized nursing positions at DSH.

DSH's long-term solution to fill vacancies for nursing level-of-care staff is to continue and/or expand partnerships with local community colleges to increase class sizes and/or number of available cohorts, with the goal of producing more RN and PT candidates available to work at DSH hospitals. DSH-Atascadero was approved by the Board of Vocational Nursing & Psychiatric Technicians in March 2020, and in collaboration with Cuesta College, increased the program class size from 30 to 45 students, with two cohorts per year. However, plans to expand these cohorts were significantly impacted during the COVID-19 pandemic. Class sizes were reduced to accommodate spacing restrictions, the number of applications received for these programs dropped, and clinical training sites were limited. DSH-Napa contracts with

Napa Valley College which includes the existing two cohorts per year and added an additional six students each, for a total size of 36 students per cohort.

DSH-Napa Psychiatric Residency Program - St. Joseph's Medical Center (SJMC)

The psychiatric Residency Program at St. Joseph's Medical Center (SJMC) was approved for ongoing accreditation in February 2023, and the first cohort of seven residents began their training in July 2021. The program is now in its third year and has three cohorts for a total of 20 residents annually participating. Based on data for Years 1 and 2 Residents, each resident in Year 1 provides two blocks of 160 hours each, totaling 320 hours of care, and each resident in Year 2 provides four blocks of 160 hours each, totaling 640 hours. Over the course of these two years, residents have worked a total of 6,720 hours, equivalent to 3.8 personnel years (PYs).

DSH-Patton Psychiatric Residency Program

DSH received resources in the Budget Act of 2023 to add a second residency program at DSH-Patton based on the successes of the DSH-Napa Psychiatric Residency Program by leveraging established DSH partnerships with community colleges for PT programs. DSH tentatively identified a learning institution to partner with to create the new on-site psychiatry training program, which would have residents perform the same duties and responsibilities of an inpatient psychiatry resident.

Psychiatric Fellowships

The Budget Act of 2023 additionally included resources to expand or develop fellowship programs across all five State Hospitals, with the objective of providing new psychiatrists with specialized training focused on the unique needs of state hospital patients. These forensic fellowships will provide clinicians invaluable opportunities to gain experience and familiarity with forensic populations and provide the Department an opportunity for future recruitment. DSH currently partners with University of California, Davis (UC Davis) to provide training to four forensic fellows a year at DSH-Napa.

Resources received in the Budget Act of 2023 were allocated to expand upon DSH's current forensic fellowships by establishing geriatric psychiatry fellowships, designed to provide the specialized training needed to serve the aging population of DSH patients. These fellowships would establish training sites at DSH-Napa and eventually DSH-Metropolitan; the two facilities currently operating on-site skilled nursing facilities (SNF).

Finally, given a significant percentage of the patient population has a co-occurring substance use disorder, the Budget Act of 2023 provided resources to develop an

addiction psychiatry fellowship at DSH-Napa to establish a pipeline of psychiatrists prepared to treat dual diagnoses.

Office of Continuing Education and Medical Advancement (CEMA)

The Budget Act of 2023 provided DSH the authority to establish the Office of Continuing Education and Medical Advancement (CEMA), which would oversee Continuing Medical Education (CME) at DSH. CME is an educational requirement for psychiatrists to maintain licensure. Additionally, CME is now a critical component of maintaining board certification for psychiatrists because the American Board of Psychiatry and Neurology (ABPN) recently changed the Maintenance of Certification (MOC) requirement from testing to focus it on CME. DSH has been piloting a university quality statewide CME program for several years focused on psychopharmacology and forensic topics.

The Budget Act of 2023 included resources for the development and implementation of pipeline, recruitment, and retention initiatives to sustain and grow DSH's psychiatric workforce.

Resident Rotations

Also in the Budget Act of 2023, DSH received resources to increase the amount of rotation opportunities to post-graduate residents. Providing physicians opportunities to gain exposure to the Department and DSH patient populations increases the possibility of attracting future physicians with DSH population experience, and also affords experience applying that subspecialty knowledge in a large public sector health system.

PROGRAM UPDATE

Psychiatric Technician (PT) Graduation Rates

DSH continues to partner with local community colleges to offer education and training programs to provide an adequate supply of PTs for the state hospitals. The below table displays actual graduation rates from cohorts conducted from calendar year 2019 through summer 2023 at DSH-Atascadero and DSH-Napa.

DSH-Atascadero

Cohorts	Number of Attendees	Number of Graduates	DSH Hires
2020	60	44	32
2021	60	53	10
Spring 2022	26	17	10
Summer 2022	30	18	15
Fall 2022	33	17	11
Spring 2023	28	22	11
Summer 2023	32	22	22

DSH-Napa

Cohorts	Number of Attendees	Number of Graduates	DSH Hires
Spring 2020	24	16	2
Fall 2020[1]	N/A	N/A	N/A
Spring 2021	30	19	11
Fall 2021[2]	N/A	N/A	N/A
Spring 2022	26	17	4
Fall 2022[3]	17	14	TBD
Spring 2023[4]	12	TBD	TBD

[1] No cohort held due to COVID-19 Restrictions
[2] No new students
[3] Data expected December 2023
[4] Data expected May 2024

DSH-Napa Residency Program Update

Recruitment for the upcoming fourth cohort started September 2023 with almost 600 applications received. These hundreds of applications are currently being reviewed to schedule interviews and determine admission decisions for the new cohort.

As of the 2024-25 Governor's Budget, DSH is discussing a possible expansion of the residency program with SJMC. An update will be provided in the 2024-25 May Revision.

Residency Program at DSH-Patton

The DSH-Patton Psychiatry Residency Program is in the early stages of development. Following the passage of the Budget Act of 2023, the partnership identified with Eisenhower Medical Center to develop an on-site psychiatry training program dissolved. DSH is currently assessing alternative options for community partnership opportunities and program accreditation and will provide an update in the 2024-25 May Revision.

Psychiatric Fellowships

As of the 2024-25 Governor's Budget, DSH has made great strides in implementing the three new fellowship rotation offerings.

- The Stanford University Forensic Psychiatry Rotation agreement has been implemented, and Stanford fellows are already rotating at DSH-Atascadero.
- The University of California, Los Angeles (UCLA) Forensic Psychiatry Rotation agreement has been completed and fellows are scheduled to begin rotations at DSH-Metropolitan in Fall 2023.
- The University of California, San Francisco (UCSF) Public Psychiatry Rotation agreement is in its final stages and will be executed by December 2024, with fellows anticipated to begin rotation in Spring 2024.

Other fellowship rotation agreement opportunities are currently under discussion with prospective schools. DSH is in the early development stages of two fellowship programs at DSH-Coalinga and DSH-Patton. DSH will continue to pursue these agreements and any additional opportunities for expansion and provide an update in the 2024-25 May Revision.

Office of Continuing Education and Medical Advancement (CEMA)

As of the 2024-25 Governor's Budget, CEMA has successfully been established and is currently focused on coordinating with various stakeholders to negotiate agreements for the psychiatric fellowships and resident rotation sites.

DSH continues to develop community and educational partnerships to further grow the psychiatric workforce pipeline and will provide an update in the 2024-25 May Revision.

Resident Rotations

As of the 2024-25 Governor's Budget, DSH is in the process of securing an agreement with Kaiser Foundation Hospital and The Permanente Medical Group, Inc. at DSH-Napa, which is anticipated to be executed by December 2023.

Other resident rotation agreement opportunities are currently in the early stages of discussion with prospective schools to expand resident rotations in the new academic year, starting July 2024. An update will be provided in the 2024-25 May Revision.

STATE HOSPITALS
SKILLED NURSING FACILITY (SNF) LEVEL OF CARE NEEDS
Informational Only

SUMMARY

As of the 2024-25 Governor's Budget, the Department of State Hospitals (DSH) continues to evaluate options to meet the Skilled Nursing Facility (SNF) needs of DSH's aging and high acuity patient population, as the current number of DSH SNF beds remains insufficient to meet the needs of existing and future patients. Further impacting this issue, the SNF building repairs at DSH-Metropolitan continue to experience construction delays, pushing the project completion date to March 2024.

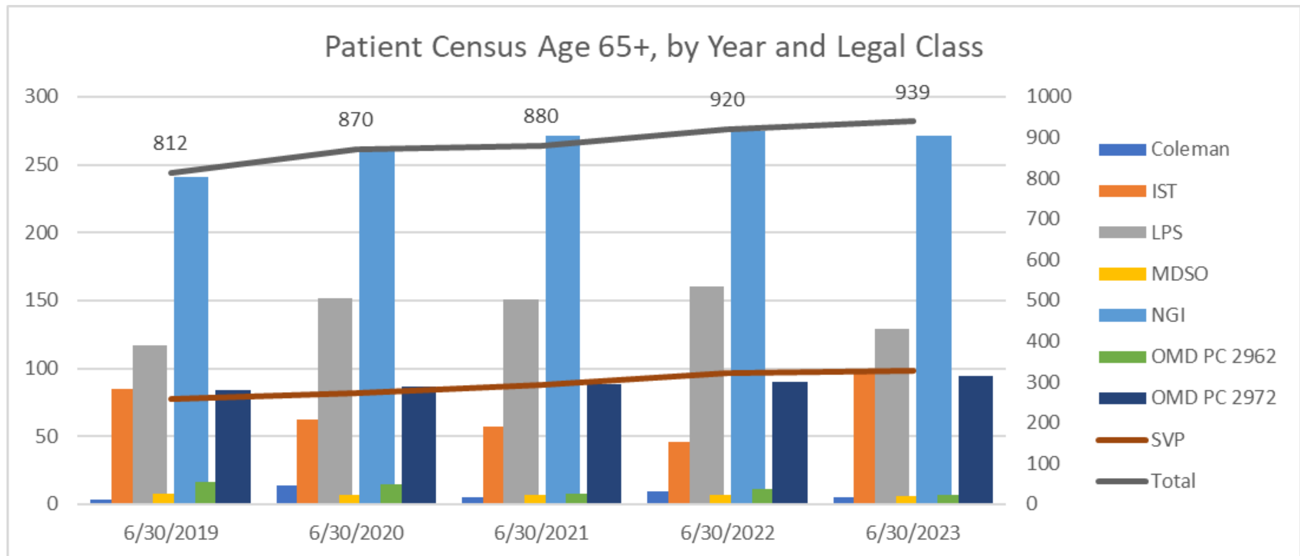
BACKGROUND

As the administrator of the nation's largest inpatient forensic mental health state hospital system, DSH is responsible for the daily care of over 7,000 patients; some of whom, due to either the severity of their mental illness or the crimes they have committed, have long lengths of stay. The following provides by commitment type, the average number of patient days for patients in census at the end of fiscal year (FY) 2022-23.

Commitment Type	Average Patient Days
Coleman/CDCR	107.6
Incompetent to Stand Trial (IST)	131.4
Lanterman-Petris Short (LPS)	2,500.7
Mentally Disordered Sex Offender (MDSO)	4,524.4
Not Guilty by Reason of Insanity (NGI)	4,043.7
Offender with Mental Health Disorder (OMD) PC 2962	310.2
OMD PC 2972	2,580.4
Sexually Violent Predators (SVP)	3,938.5

Mental, physical, and dental health care are provided for patients over the course of their stay at DSH. Depending on a patient's length of stay, their health care may include geriatric, end-of-life care, chronic illnesses, or recuperation from major illnesses or surgery requiring either interim or long-term skilled nursing care.

In recent years, the number of DSH patients aged 65 and over has continued to increase. As illustrated in the graph and table below, DSH has observed an increase of 16% over the last five years in the number of patients aged 65 and over.



While older patients already experience a higher level of prevalence for multiple medical conditions, current research reveals patients with schizophrenia experience accelerated aging and development of age-related illnesses 20 years earlier than expected and suffer from a dramatically decreased life expectancy. As of June 30, 2023, 51% of DSH's population had a diagnosis of schizophrenia. Moreover, mental illness, particularly psychotic spectrum disorders, bipolar disorders, and depressive disorders, are associated with increased prevalence of chronic diseases including asthma, arthritis, cardiovascular disease, cancer, diabetes, and obesity. As of June 30, 2023, 22% of DSH's population had a diagnosis of schizoaffective disorder and 4% had a diagnosis of bipolar disorder.

DSH currently operates three licensed[1] SNF units; two located at DSH-Metropolitan and one at DSH-Napa. As of June 30, 2023, there were 96 active SNF beds at DSH-Metropolitan and 29 at DSH-Napa, for a combined total of 125 active SNF beds. This limited capacity must also accommodate SNF patients transferred from DSH-Atascadero and DSH-Patton. However, due to system limitations, DSH-Metropolitan and DSH-Napa are not able to serve SNF patients committed to DSH-Coalinga as Sexually Violent Predators (SVP).

For DSH-Coalinga, and any other facilities unable to place their SNF patients into one of the three existing DSH SNF units, DSH contracts out with community facilities when possible. However, community options pose challenges which often make placement difficult, including the limited availability of community beds, in addition to the challenge that even when an available bed is identified, many community options are unwilling to accept forensic commitments, particularly those with sexual

[1] SNF beds are licensed and regulated by the California Department of Public Health (CDPH) pursuant to California Code of Regulations (CCR) Title 22, Division 5, Chapter 3. DSH SNF beds are also federally certified by Centers for Medicare and Medicaid Services (CMS) and therefore must also comply with CMS regulations and reporting requirements.

offenses. DSH has taken steps to convert existing Residential Recovery Units (RRU) to meet the increased medical needs of patients with a higher level of acuity. As of May 2023, an additional RRU at DSH-Coalinga was converted to an Intermediate Care Facility (ICF) to accommodate their increasingly geriatric population.

In the Budget Act of 2023, DSH reported three state hospitals were exploring both internal and external options to increase SNF bed capacity, with DSH in collaboration with the Department of General Services (DGS) to develop a study detailing options to operationalize a SNF Unit at DSH-Coalinga.

PROGRAM UPDATE

As of the 2024-25 Governor's Budget, DSH is continuing to explore solutions to meet the SNF needs of DSH's aging and high acuity patient population. A study detailing estimated costs of developing a SNF Unit at DSH-Coalinga, recommendations, and alternatives is currently being finalized and will be evaluated for inclusion in future budget requests.

Construction progress on the SNF building at DSH-Metropolitan continues to be impacted by the difficulties encountered by the contractor in acquiring both personnel and construction materials to complete this project. Due to ongoing construction delays, as of the 2024-25 Governor's Budget, DSH and DGS expect the SNF building roof repairs to be completed in March 2024. An update will be provided in the 2024-25 May Revision.

CONTRACTED PATIENT SERVICES
FELONY MENTAL HEALTH DIVERSION PROGRAM (PILOT)
Informational Only

SUMMARY

The Department of State Hospitals (DSH) continues efforts to fully expend the resources allocated as part of the Diversion pilot program by funding and expanding the 28 existing county Diversion programs. As of June 30, 2023, 354 additional individuals have been diverted to county-run programs, bringing the total number of diverted participants to 1,539. DSH will continue to provide status updates on the Diversion pilot program through its completion on June 30, 2025[1].

BACKGROUND

The Budget Act of 2018 provided pilot funding for DSH to develop new Diversion programs by contracting with various counties throughout California to serve individuals with serious mental illness diagnoses, such as schizophrenia, schizoaffective disorder, or bipolar disorder, who have been found or have the potential to be found Incompetent to Stand Trial (IST) on felony charges. In the following years, additional investments in the pilot program have been made to expand its footprint in the state and allow for additional treatment slots.

<u>Funding for Existing County Programs</u>

Of the original funding provided in the Budget Act of 2018, 99.5% was allocated by November 15, 2022, securing contracts with the following 24 counties:

- Alameda
- Contra Costa
- Del Norte
- Fresno
- Humboldt
- Kern
- Los Angeles
- Marin
- Placer
- Riverside
- Sacramento
- San Bernardino
- San Diego
- San Francisco
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz[2]
- Siskiyou
- Solano
- Sonoma
- Ventura
- Yolo

<u>Diversion Pilot Funding Reappropriation</u>

In the 2023-24 May Revision, DSH requested to reappropriate any remaining contract funds provided in the Budget Act of 2018 to allow counties time to expend the

[1] The Department of State Hospitals (DSH) continues to provide status updates on the Diversion Pilot program, while providing permanent Diversion program updates in IST Solutions (see Section C9).
[2] Santa Cruz program ended October 2022.

remaining balances of their diversion program funding and meet their contracted number of individuals to be diverted under their contracts. This extension was needed due to activation delays of county diversion programs resulting from the COVID-19 pandemic.

New Pilot County Program Funding

Following the successes of initial efforts, the Budget Act of 2021 provided DSH additional resources to expand the Diversion pilot program to new, currently non-participating counties. In fall 2021, DSH provided intensive technical assistance to aid counties in developing their programs, resulting in five new participating county Diversion programs in Madera, Nevada, San Joaquin, Tulare, and Tuolumne counties. Following the full execution of the contracts, implementation check-in meetings with each of the counties began in fall 2022 to assist county stakeholders with the activation of their Diversion programs.

Expanding Existing County Programs

Also provided in the Budget Act of 2021 were resources to allow participating counties to expand their existing Diversion programs by up to 20% if they met the following criteria:

- Defendants diverted must be found felony IST
- Diagnostic criteria for entry must include any mental health diagnosis allowed under Penal Code (PC) 1001.36
- Clients must not pose an unreasonable safety risk to the community
- A connection exists between the alleged crime and the defendant's symptoms of mental illness or conditions of homelessness

In the 2023-24 May Revision, DSH reported 20 counties had elected to participate, accounting for 294 new Diversion slots.

Supplemental County Housing Funding

DSH received funds in the Budget Act of 2021 to expand Community Based Restoration (CBR) and Felony Mental Health Diversion (Diversion) programs. As part of the expansion, DSH provided counties with an opportunity to establish new or expand their existing diversion programs by offering Supplemental County Housing funds for diverting and providing housing services to clients found incompetent to Stand Trial (IST) per Penal Code §1370 and on the DSH waitlist. As of the Budget Act of 2023, 17 counties participated in the program and received Supplemental Housing funds for diverting and providing housing services to clients on the DSH waitlist.

JUSTIFICATION

New County Pilot Programs

As of the 2024-25 Governor's Budget, DSH can report the five new Diversion programs reported in the 2023-24 May Revision, in Madera, Nevada, San Joaquin, Tulare, and Tuolumne counties, have all activated and begun client enrollment. Nevada County has enrolled two of eight contracted Diversion clients, while San Joaquin County has enrolled 11 of 26 contracted Diversion clients, and Tulare County reported one enrolled Diversion client out of 13 county spots. Madera and Tuolumne counties did not enroll Diversion clients during the reporting period. All programs continue to work actively to identify eligible candidates for program participation.

In July 2023, DSH began holding monthly meetings with all pilot counties to hear about any barriers they may be facing and to provide support and technical assistance. Both Madera and Tuolumne are geographically smaller counties, and both expressed difficulties with receiving referrals and placement, due to having a smaller pool of IST patients to assess for Diversion. DSH continues to provide technical assistance to the counties and coordinates monthly meetings with them to assist with any barriers they may be experiencing.

DSH also continues to work with all counties to improve the quality of reported data, by analyzing the data submitted from all 28 participating Diversion counties. Currently, DSH collects Diversion data from participating counties every quarter. Counties who struggle to complete reports timely and accurately are provided with additional support to help with any barriers they may be facing.

DSH is in the process of developing the permanent Diversion program funded through the IST Solutions in the Budget Act of 2022 and the contract language will include updated requirements regarding counties' data reporting, including providing data to DSH monthly rather than quarterly as it currently occurs in the Diversion Pilot program. This change will allow DSH to conduct a well-timed review of data submitted to DSH and provide DSH with an opportunity to reach out to counties to resolve discrepancies sooner.

Expanding Existing County Programs

As reported above, DSH provided resources to counties participating in Diversion that wished to expand their program by up to 20% if they met certain criteria. As of June 30, 2023, 294 new Diversion slots were created in 20 counties.

Supplemental County Housing Support

As stated above, DSH provided counties with an opportunity to establish new or expand existing diversion programs by offering supplemental housing funds when they divert and provide housing services to IST patients. As of June 30, 2023, the 17 counties that participate in the program have billed for a total of $5.8 million in Supplemental Housing.

Diversion Pilot Program Data Collection Efforts and Research

As of June 30, 2023, 1,539 eligible individuals have been diverted to a county-run program. DSH continues to work with all counties to ensure the quality of data collected. The following table provides a high-level snapshot of Diversion program participants:

Diversion Program Participant Descriptive Data		
Program Information	**Total Number**	**Percentage**
Total Enrolled as of 6/30/2023	1591	100
Total Ineligible	52	3.3
Total Eligible	1539	96.7
At Risk vs. IST	**Total Number**	**Percentage**
At risk of IST[3]	599	38.9
IST	940	61.1
Waitlist	**Total Number**	**Percentage**
Removed from DSH Waitlist	650	42.2
Diagnosis	**Total Number**	**Percentage**
Schizophrenia	626	40.7
Schizoaffective Disorder	496	32.2
Bipolar Disorder	307	19.9
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (OPD)	90	5.8
Other	20	1.3
Ethnicity	**Total Number**	**Percentage**
White	401	26.1
People of Color	1138	73.9
Gender	**Total Number**	**Percentage**
Male	1021	66.3
Female	508	33.0
Other	10	0.6

[3] <11 individuals were not reported as either IST or at risk of IST. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines, with values of 11 or less represented as "<11".

Living Situation at Arrest[4]	Total Number	Percentage
Homeless	1243	81.1
Not Homeless	290	18.9
Felony Charges	**Total Number**	**Percentage**
Assault/ Battery	501	32.6
Theft	273	17.7
Robbery	206	13.4
Miscellaneous (primarily Vandalism)	158	10.3
Criminal Threats	121	7.9
Arson	116	7.5
Other (primarily weapons, drugs, FTR)	97	6.3
Obstruction of Justice	39	2.5
Kidnapping	28	1.8

Diversion Pilot Program Outcome & Predictive Data (As of 6/30/2023)

Since the launch of the pilot in 2018, enrollment in Diversion has steadily increased. Using data collected throughout the pilot, DSH can analyze and share participant predictor data outcomes and assess program impacts. Using data as of June 30, 2023, from all participating counties, DSH was able to analyze the outcomes of the 1,539 eligible Diversion participants. Of these participants, only 1,481 were included for analysis in the data tables due to several factors. The 58 clients that were not included met eligibility criteria and started their respective Diversion programs but were terminated for a variety of reasons. Some of these include: the client being transferred to another program, exceeding the two-year program limit, or the occurrence of death prior to the completion of the program.

The following tables use the dataset described above to display predictors of status in the program:

Current Status		
	Total Number	**Percent**
Still In	751	50.7
Revoked/AWOL/Re-incarcerated	396	26.7
Successful Completion	334	22.6
Total	**1481**	**100%**
Length of Stay by Current Status		
	Average	
Still In (as of 6/30/2023)	310.66	
Revoked/AWOL/Re-incarcerated	166.90	
Successful Completion	631.60	

[4] San Diego, San Francisco, and Santa Clara Counties did not provide this data in their quarterly reports.

Risk Assessment[5] Conducted		
	Total Number	**Percent**
Yes	498	70.5
No	208	29.5
Total	**706**	**100%**
Development of Treatment Plan[6]		
	Total Number	**Percent**
Intensive evaluation[7]	595	86.9
Formal RNR assessment[8]	70	10.2
Both	20	2.9
Total	**685**	**100%**

Diversion Program Participant Outcome Data		
Incompetent to Stand Trial	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
IST	144 (38.5)	230 (61.5)
At risk of IST	190 (53.4)	166 (46.6)
Homeless	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	255 (42.4)	347 (57.6)
No	79 (61.7)	49 (38.3)
Abuse of Substances	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	269 (43.7)	346 (56.3)
No	60 (61.2)	38 (38.8)
Methamphetamine Use	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Methamphetamine	141 (34.3)	270 (65.7)
No drug use/Other drugs	186 (62.0)	114 (38.0)

DSH's Diversion program participant outcome data is dynamic and unpredictable. Throughout the pilot, tracking indicators and data in various subgroups (e.g., 'IST' versus 'at risk of IST') have changed over time. Even modest changes within the

[5] Clinical assessment designed to evaluate an individual's risk of violence.
[6] Individualized course of treatment and interventions based on specific patient needs.
[7] The use of various disciplines, including psychiatry, to evaluate a patient's needs and the best course of treatment to meet those needs.
[8] Structured assessment to determine what factors elevate a patient's risk of reoffending or responding poorly to treatment, how to minimize those risk factors for the patient through a treatment plan, and how to adjust the treatment plan over time as a patient's risk factors change.

dataset of smaller numbers can have a high impact on results and determined conclusions. Additionally, data collected from the 28 participating counties, each from very disparate areas of the state with their own diverse populations, have expanded the characteristics of the sample data collected; a trend which continues as additional counties pursue Diversion programs.

As additional counties begin Diversion participation, the sample data from various subgroups may change proportionately to previous data. These observed fluctuations are likely to continue through the end of the pilot phase of the DSH Diversion program, resulting in dynamic changes in the outcomes when compared to previous quarters. DSH strives to improve upon the operational definitions of the data and refine data collection prior to the permanent program implementation to account for these dynamic fluctuations.

FORENSIC EVALUATION SERVICES
SEX OFFENDER COMMITMENT PROGRAM AND OFFENDERS WITH A MENTAL HEALTH DISORDER (SOCP/OMD) PRE-COMMITMENT PROGRAM

Informational Only

SUMMARY

The Department of State Hospitals (DSH) continues to monitor the Sexually Violent Predator (SVP) and Offenders with a Mental Health Disorder (OMD) referral trends. In the 2023-24 May Revision, DSH projected to receive a total of 357 SVP and 2,134 OMD referrals in fiscal year (FY) 2022-23. As of the 2024-25 Governor's Budget, DSH now projects to receive 410 SVP and 1,924 OMD referrals in FY 2023-24.

BACKGROUND

Prior to an individual's release from California Department of Corrections and Rehabilitation (CDCR), statute requires DSH to provide forensic evaluation services[1] to determine if the individual needs treatment in a state hospital as an SVP or OMD upon release from prison. DSH administers these services through the Sex Offender Commitment Program (SOCP) and the OMD Program. DSH employs a team of Consulting Psychologists, SVP Evaluators, and contracted forensic psychologists to provide the forensic evaluations. The forensic evaluator staffing allows DSH to complete the volume of interviews, evaluations, forensic report development, and expert witness and court testimony services required. The number of CDCR referrals for potential SVP and OMD commitments to DSH is the primary driver of the workload. Additional workload may include, but is not limited to the following:

- Completing update and replacement evaluations and report addendums, as required by the court.
- Completing recommitment evaluations in accordance with WIC 6604.
- Completing independent evaluations to resolve differences of opinion (DOP) for SVP evaluations, as required by statute.
- Developing and maintaining a robust quality assurance program, including data analytics, to target evaluators' training and/or support needs.
- Developing and implementing standardized assessment protocols, policies, and regulations.
- Preparing for, and participating in, expert witness and court testimony.

In the Budget Act of 2023, DSH did not request a change in funding or position authority but did report a projected decrease in referrals for both SVP and OMD evaluations for FY 2022-23.

[1] DSH continues to rely on the existing video conferencing infrastructure throughout the state. This has allowed DSH to conduct most forensic evaluations and provide much court testimony virtually, significantly reducing travel costs for SVP and OMD evaluations.

<u>SOCP Program</u>

In accordance with WIC 6601(b), CDCR and the Board of Parole Hearings (BPH) are responsible for screening CDCR inmates to determine whether an individual is likely to be an SVP. If CDCR and BPH determine an individual is likely to be an SVP, BPH refers the individual to DSH for forensic psychological evaluation. For those referred, statue requires DSH to complete two forensic psychological evaluations to determine if the individual meets the statutory criteria for civil commitment as an SVP. In addition, the statute requires DSH to refer cases in which evaluations indicate an individual meets criterion to the county District Attorney's Office no less than 20 days prior to the individual's release from prison.

<u>OMD Program</u>

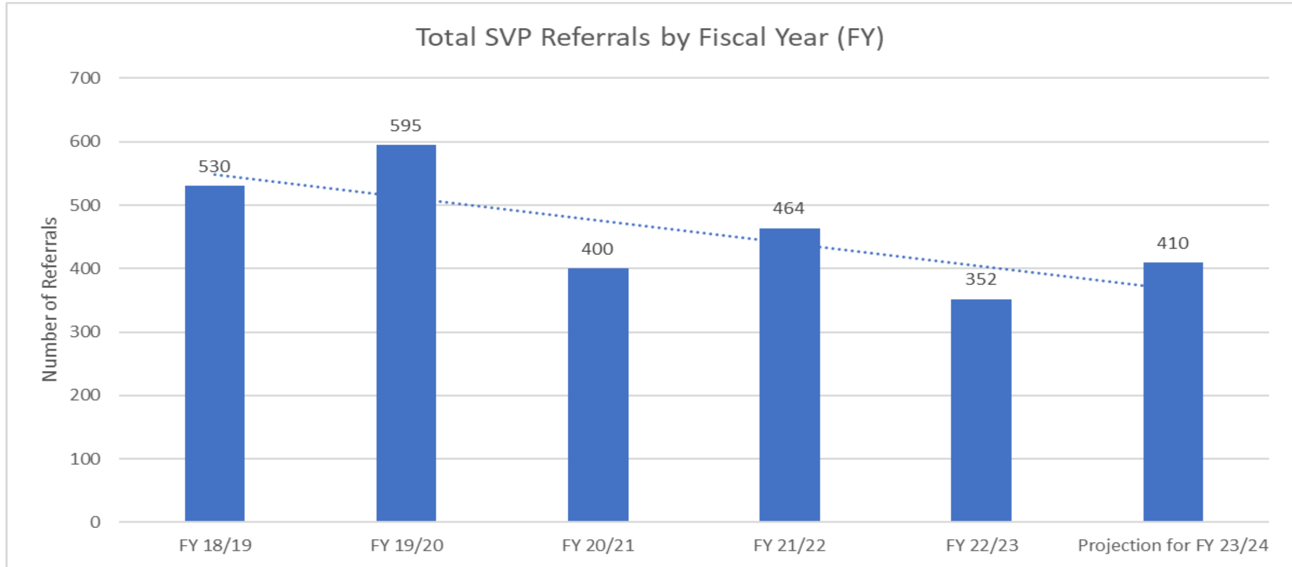
Pursuant to Penal Code (PC) 2960–2981, CDCR evaluators conduct a forensic evaluation of inmates who have been in CDCR mental health programs and who have a violent commitment offense prior to the individual's release on parole. If the CDCR evaluator determines the inmate has a severe mental health disorder and could meet the criteria for OMD commitment, CDCR refers the inmate to DSH for an additional forensic evaluation. The CDCR Chief Psychiatrist then reviews the reports to determine if the inmate meets the criteria for commitment as an OMD. If the Chief Psychiatrist certifies the criteria are met, BPH transfers the inmate to a state hospital for treatment as a special condition of parole.

PROGRAM UPDATE

<u>SOCP Program</u>

DSH received 352 SVP evaluation referrals in FY 2022-23. This is a 24 percent decline in referrals compared to FY 2021-22 and only 1.2 percent less than the projection of 357 referrals for FY 2022-23. However, trends indicate SVP referrals for FY 2023-24 may be higher than FY 2022-23, indicating a return to FYs 2020-21 and 2021-22 levels. Between August and November 2023, DSH averaged 57 referrals per month, which is nearly double the 30 average referrals per month received between January and July 2023. Currently, DSH projects 410 referrals for FY 2023-24 an increase from the 357-referral projection for FY 2022-23. Each referral requires at least two evaluations further increasing the workload for each referral received.

The chart below shows the total SVP referrals by fiscal year from FY 2018-19 to the projection for FY 2023-24.

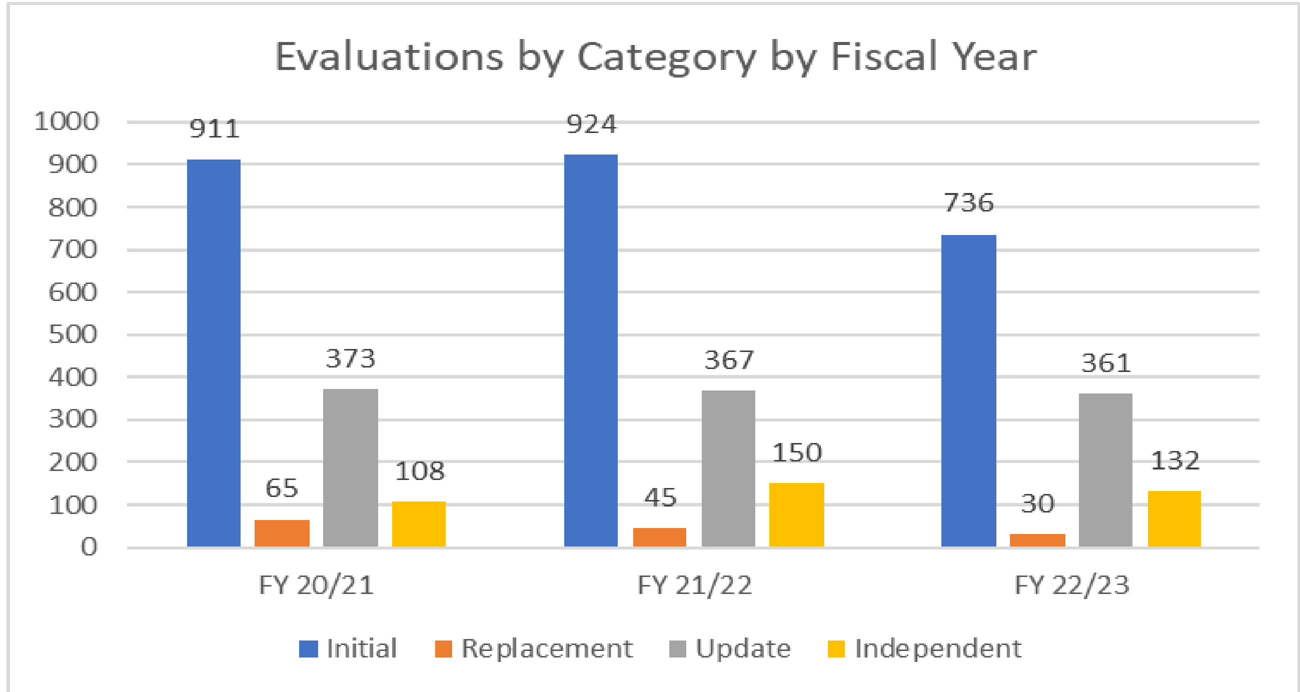


Based on actuals from prior years and the monitoring of current year trends, DSH projects a total of 410 SVP referrals for FY 2023-24, a 14.2 percent increase from FY 2022-23. The projection for FY 2023-24 is based on an annualized rate of the SVP referrals received in the past six months.

DSH is currently monitoring a recent surge resulting in the increase of SVP referrals due to changes in sentencing laws. These statute changes are resulting in the resentencing of eligible individuals serving prison terms, yielding in the earlier release of a larger number of SVP-eligible individuals from prison. Considering SVP referrals are unstable at this time, DSH must maintain sufficient resources until the trend stabilizes to ensure enough resources are available to meet statutory requirements. DSH will continue to monitor SVP referral trends and provide an update in the 2024-25 May Revision.

For each SVP referral received, DSH performs a minimum of two initial evaluations. When there is a difference of opinion (DOP) between two forensic civil service evaluators initially assigned by DSH to perform SVP evaluations, DSH is statutorily required to assign two additional independent evaluators (who are not state government employees) to assess the individual. In addition, the Forensic Services Division (FSD) performs update evaluations (assigned when a court requests an update of an evaluation on an SVP patient pending trial) and replacement evaluations (assigned when an evaluator is not available to perform an update of an evaluation they performed earlier).

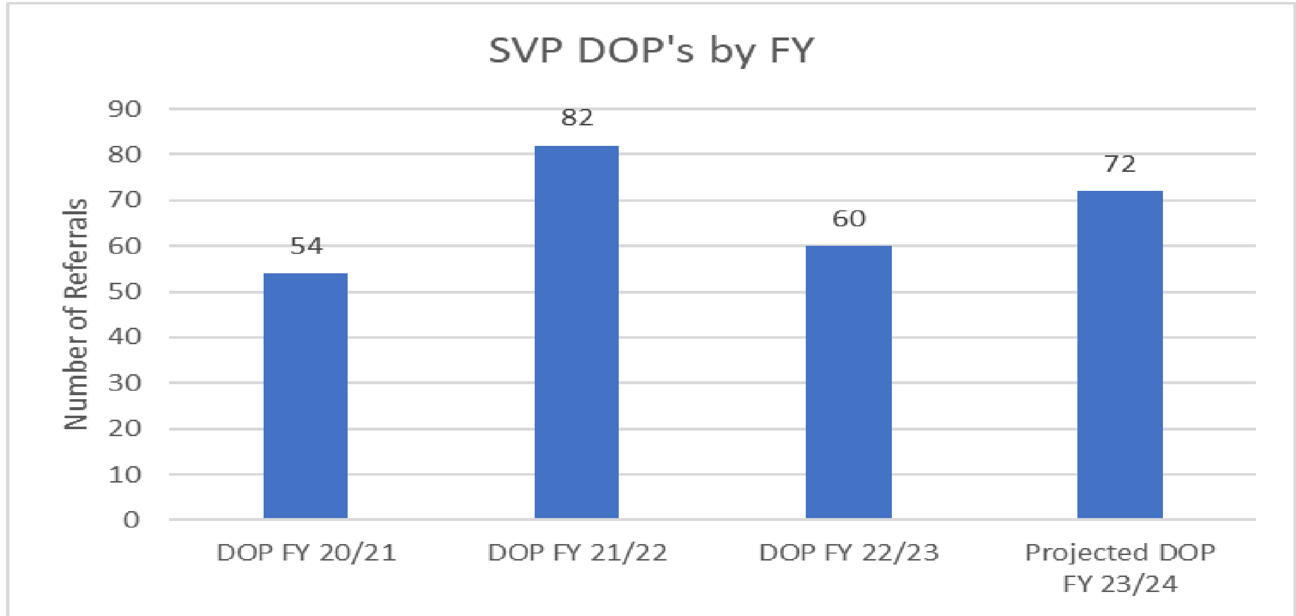
Please refer to the chart below which displays the total number of evaluations by category from FY 2020-21 to FY 2022-23.



For FY 2022-23, there was a decrease in initial evaluations due to the lower amount of SVP referrals received. However, based on the projected increase of SVP referrals for FY 2023-24 (see previous SVP referral chart on page 3), initial evaluations are also projected to increase.

Update evaluations are likely to remain stable for FY 2023-24 as the number of referrals has remained constant. DSH will continue to monitor the rate of update referrals requested by justice partners and provide an update in the next caseload estimate. Additionally, in FY 2022-23 DSH evaluators testified in 385 SVP court cases. The workload involved in providing testimony for probable cause hearings and jury trials is equal to approximately two SVP evaluations as each court case includes at least two evaluators; four in the case of DOP.

The chart below shows the number of SVP DOP referrals for FY 2020-21 to FY 2023-24 projections.

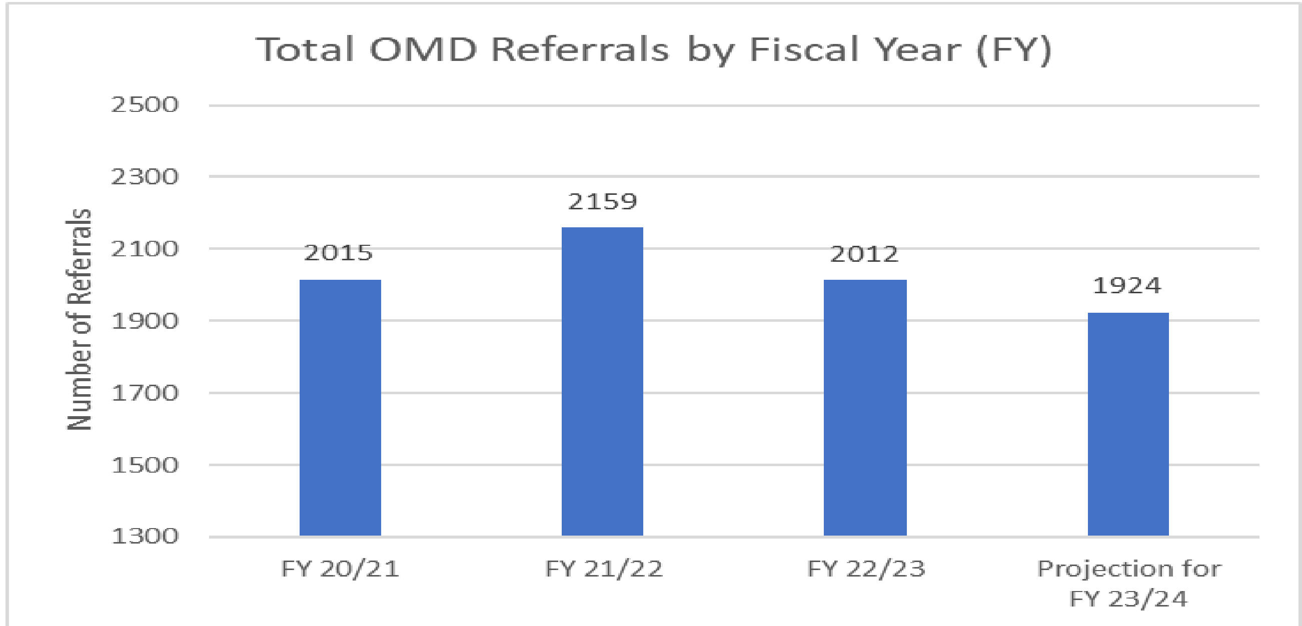


For FY 2022-23, DSH previously projected 80 DOP cases and the actual total received was 60. This number is 27 percent lower than FY 2021-22 and 10 percent higher than FY 2020-21. Based on prior FY actuals and the monitoring of current year trends, DSH projects a total of 72 DOP cases for FY 2023-2024.

Beginning in FY 2022-23, DSH began paying an additional $500 per rush evaluation to contracted independent evaluators. During this time, 132 SVP referrals were received with fewer than 75 days from referral to release date. Of these referrals, 28 became DOPs (resulting in 56 evaluations). Referrals received with 75 days or less to release date that become DOPs do not provide adequate time to process the required independent evaluations, resulting in the rush fee in order to meet statutory timelines. DSH is developing efficiencies to reduce the impact of rush referrals, while coordinating with BPH to send referrals 180 days before the release date, in accordance with statutory requirements.

OMD Program

In FY 2022-23, DSH received 2,012 OMD referrals for evaluation, a decrease of six percent from the projected total of 2,134. Trends show OMD referrals for FY 2023-24 will be lower than the prior three FYs with a projected total of 1,924. The following chart shows the total OMD referrals from FY 2020-21 to the projection for FY 2023-24.



The total number of OMD referrals received for FY 2022-23 was seven percent lower than FY 2021-22. Based on trends, DSH projects OMD referrals to be five percent lower than the prior FY. The projection for FY 2023-24 is based on the OMD referrals received in the past six months and annualized. DSH will closely monitor to determine if the trend changes.

DSH will continue to work closely with the CDCR and BPH to determine if there will be workload impacts to the SOCP and OMD program and provide an update in the 2024-25 May Revision.

STATE HOSPITALS
CAPITAL OUTLAY BUDGET CHANGE PROPOSALS

Please see the [Department of Finance (DOF) website](#) for all Capital Outlay Budget Change Proposals (COBCPs).

POPULATION PROFILE
Penal Code 2684 (*Coleman*) Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits *Coleman* patients pursuant to Penal Code (PC) 2684: Treatment of Prisoners. The *Coleman* patients are California Department of Corrections and Rehabilitation (CDCR) patients, who are transferred from CDCR for inpatient mental health care with the expectation that they will return to CDCR (pursuant to PC 2685) when they have reached maximum benefit from treatment. If they are still mentally ill at the end of their prison term, they may receive further state hospital treatment as an Offender with a Mental Health Disorder (OMD) if they meet the criteria under PC 2962. Additionally, patients who do not meet the criteria pursuant to PC 2962 may be treated at DSH either as a parolee with a mental health disorder pursuant to PC 2974, or as a Lanterman-Petris-Short (LPS) civil commitment.

Legal Statutes and Commitments

- PC 2684 – Coleman Prisoner from CDCR

Requirements for Discharge

The goal of DSH is to provide each *Coleman* patient with the appropriate treatment to stabilize their mental health symptoms and gain the necessary skills to safely transition and reintegrate into the appropriate environment within CDCR. A patient may be eligible for discharge from DSH when the Interdisciplinary Treatment Team determines that the patient has met the requested treatment outcome expectations, the current treatment goals and objectives, and the appropriate continuation of care has been arranged. A patient may be discharged directly into the community when they are institutionally released from CDCR.

DSH Treatment Continuum & Services

The focus of treatment for the *Coleman* population is on psychiatric stabilization. A number of *Coleman* patients are sent to DSH because of complicated presentations, such as complex medical diagnoses, cognitive issues, or developmental disabilities along with mental illness. In addition to psychiatric and medical services, psychosocial treatments are provided with a focus on helping the patient manage their mental illness symptoms and reintegrate back into a prison environment when discharged from the state hospital.

Programs

DSH provides treatment to *Coleman* patients through inpatient care within State Hospitals at DSH-Atascadero, DSH-Coalinga, and DSH-Patton.

DSH Coleman Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, and Patton State Hospitals.

Population Data

In fiscal year (FY) 2022-23, the *Coleman* patient population remained relatively stable with an average census of 116 patients in July 2022 and ending with an average census of 114 in June 2023.

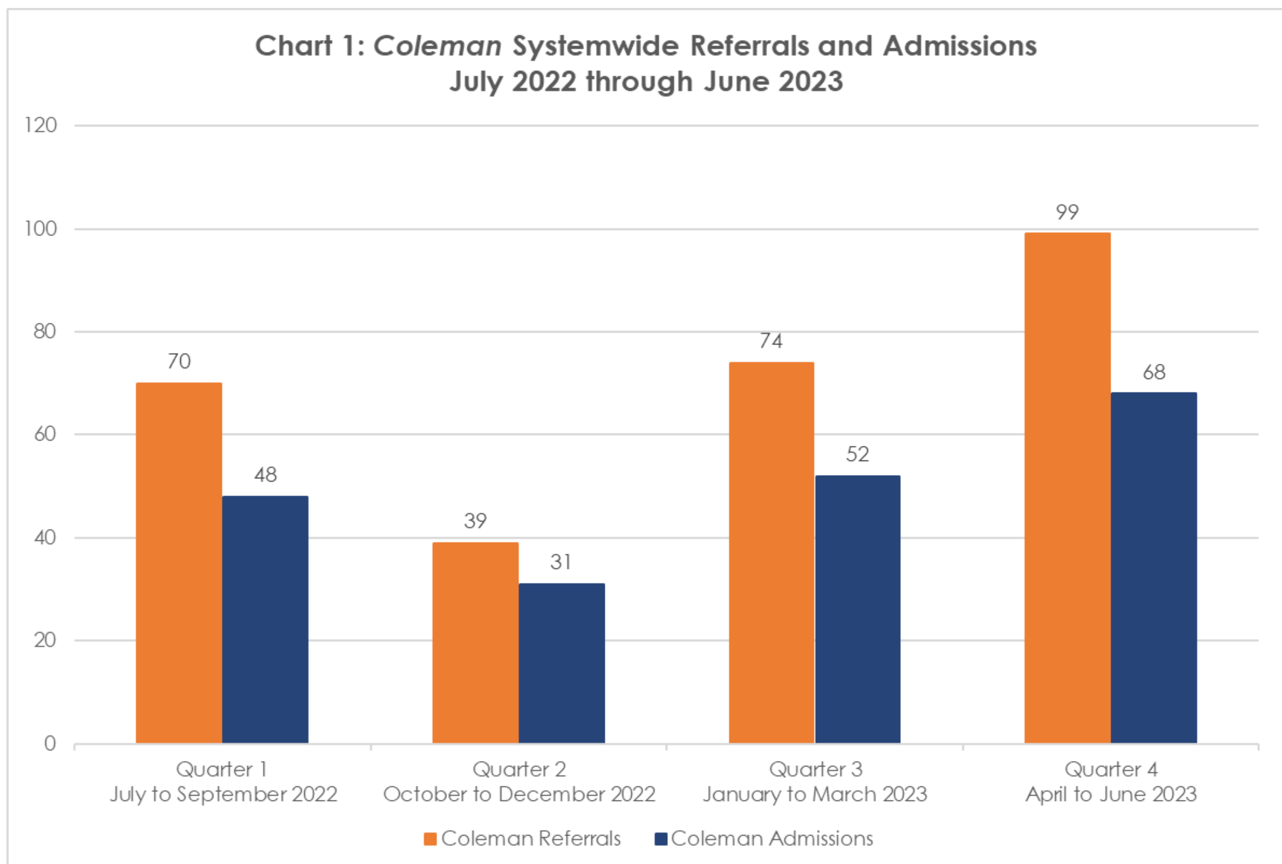
As referenced in Table 1, there were noticeable declines in comparison to prior FY 2021-22 as noted through patients served, average daily census, average length of stay and discharges. Prior FY 2021-22 is an outlier year as there were a number of patients who carried over from FY 2020-21 as a result of the COVID-19 pandemic, which resulted in increased discharges and average length of stays. COVID-19 outbreaks at the State Hospitals and the CDCR prisons in caused *Coleman* patients, who were otherwise ready to discharge, to remain at DSH hospitals until DSH or CDCR quarantines could be lifted. FY 2022-23 data reflects operations that continued to experience COVID-19 outbreaks throughout the year.

The table on the following page summarizes key statistics across the *Coleman* population.

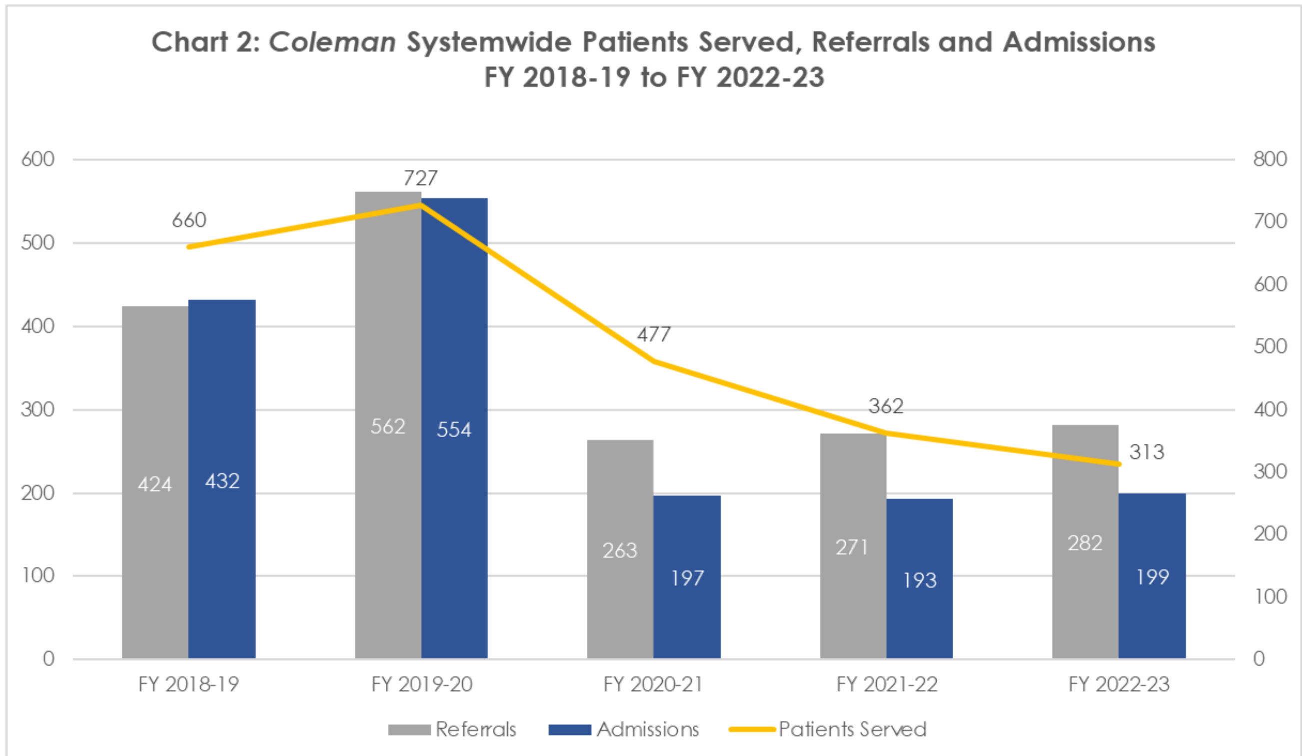
Table 1: *Coleman* Patient Data Summary[1]

***Coleman* Patient Data**	**FY 2021-22**	**FY 2022-23**	**Percent Change from Prior FY**
Patients Referrals	271	282	4%
Admissions	193	199	3%
Patients Served	362	313	-14%
Average Daily Census	160.5	105.0	-35%
Average Length of Stay	288.8	283.8	-2%
Discharges	233	189	-19%

In FY 2022-23, 282 *Coleman* patients were referred to DSH for psychiatric stabilization treatment, an increase of four percent from FY 2021-22. Chart 1 displays *Coleman* systemwide referrals and admissions for FY 2022-23. Chart 2 displays a five-year period of referrals and admissions with a trend line of patients served over the years.



[1] Patient referrals excludes other inpatient program transfers and court returns. Rescinded, rejected, and other cancelled referrals are included. Patient admissions include other inpatient program transfers. Patients served excludes other inpatient program transfers.



The chart above (Chart 2), displays 199 total admissions in FY 2022-23, a three percent growth in admissions from the prior FY. During this time, the Pending Placement List has remained steady with minor fluctuations based on the number of patients referred by CDCR at any given time. All patients referred for intermediate care treatment are subjected to court mandated timelines and must be admitted within 30 days for intermediate care facility referrals and 10 days for acute care referrals, barring any medical holds.

As a result of the CDCR referrals accepted, DSH admitted 199 *Coleman* patients in FY 2022-23 with an average of 17 admissions per month. Chart 3 displays *Coleman* admissions by quarter and the average monthly admissions rate.

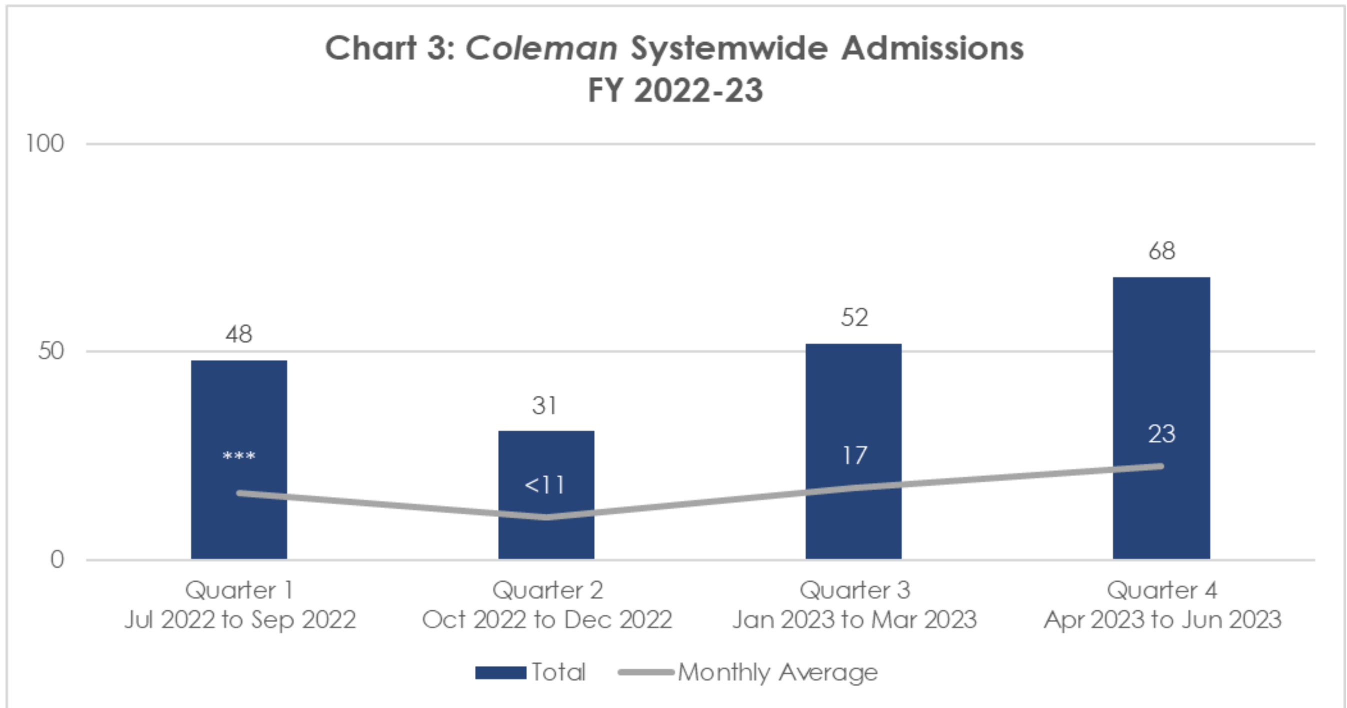


Table 2 below displays the number of patients treated across the year.

Table 2: *Coleman* Patients Served[2]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	660	727	477	362	313

Discharge Data

DSH discharged 189 *Coleman* patients with an average length of stay of 283.8 days and a median length of stay of 221 days. Sixteen percent of *Coleman* patients discharged within the first 90 days of their stay, 40 percent of the *Coleman* patients discharged within the first 180 days of their stay and 74 percent of the *Coleman* patients discharged within the first year of their stay. Table 3 displays length of stay by quarter.

Table 3: *Coleman* Patient Length of Stay by Quarter – FY 2022-23

***Coleman* Length of Stay**	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	306.6	296.3	298.7	238.4	283.8
Median Length of Stay	220.5	229.0	236.0	220.5	221.0
Discharged Count	45	43	50	51	189

[2] Patients served excludes other inpatient program transfers.

POPULATION PROFILE
Incompetent to Stand Trial Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits individuals found Incompetent to Stand Trial (IST) under Penal Code (PC) section 1370: Inquiry into the Competence of the Defendant Before Trial or After Conviction. Individuals found IST have been accused of felony crimes and are referred to DSH after a court has determined that they are unable to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. The court commits these defendants to DSH for treatment specifically designed to enable the defendant to proceed with the trial. DSH provides treatment across a continuum of care, which includes inpatient and outpatient settings. Patients receive competency-based treatment and return to county custody once they have regained competency and can effectively assist in their trial proceedings, are determined to be unlikely to be restored to competency in the foreseeable future or are within 90-days of their maximum commitment for competency treatment.

Legal Statutes and Commitments

- PC 1370- Incompetent to Stand Trial
- PC 1370, subdivision (b)(1) – Unlikely to Regain Competency
- PC 1370, subdivision (c)(1) – Maximum Commitment
- PC 1372 – Certificate of Restoration
- PC 1372, subdivision (e) – Continued Treatment Until Trial Commencement

Requirements for Discharge

An IST patient cannot be confined for longer than is reasonably necessary for restoration of competency or determination that competency cannot be restored. The maximum IST commitment time is two years[1]. An IST commitment ends when either: (1) the defendant obtains certification that he or she has regained competency, pursuant to PC section 1372; (2) the maximum time for confinement runs out, pursuant to PC 1370 (c)(1); or (3) DSH determines there is no substantial likelihood a patient will regain competency in the foreseeable future, pursuant to PC 1370 (b)(1). If a patient has not regained competency to stand trial by the end of their IST commitment term or is determined there is no substantial likelihood, he or she will regain competency in the foreseeable future, the patient must be returned to the committing county. Patients may return for further hospitalization under a civil

[1] Effective January 1, 2019, the maximum term for ISTs was reduced from three years to two years, pursuant to SB 1187.

commitment once civil proceedings pursuant to the Lanterman-Petris-Short (LPS) Act have concluded.

As defined in PC 1370(b)(1), a patient may be deemed by their treatment team as unlikely to regain competency. Upon notification to the Sheriff of the county of commitment, the patient must be picked up within ten days and returned to county custody. Often, the county will pursue other means to ensure the patient receives treatment and care, including securing a conservatorship and referring the individual back to the state hospital under a conservatorship commitment.

In the event a patient is nearing their maximum term of commitment, the state hospital, pursuant to PC 1370(c)(1) must notify the Sheriff, who must pick up the patient who is within 90 days prior to the expiration of the commitment term within ten days of notice by DSH. In prior years, DSH noted counties did not consistently retrieve their patients promptly, requiring patients to remain on the census for extended periods. In FY 2022-23, when applying the average length of stay for an IST patient, this practice resulted in a loss of 14 IST patients served between PC 1370 (b)(1) and PC 1370(c)(1) individuals. Assembly Bill 133 amended PC 1372 (a)(3)(C)[2] which specifies that counties will be billed for the costs of care for any patients remaining in a facility beyond ten days from notice to the Sheriff.

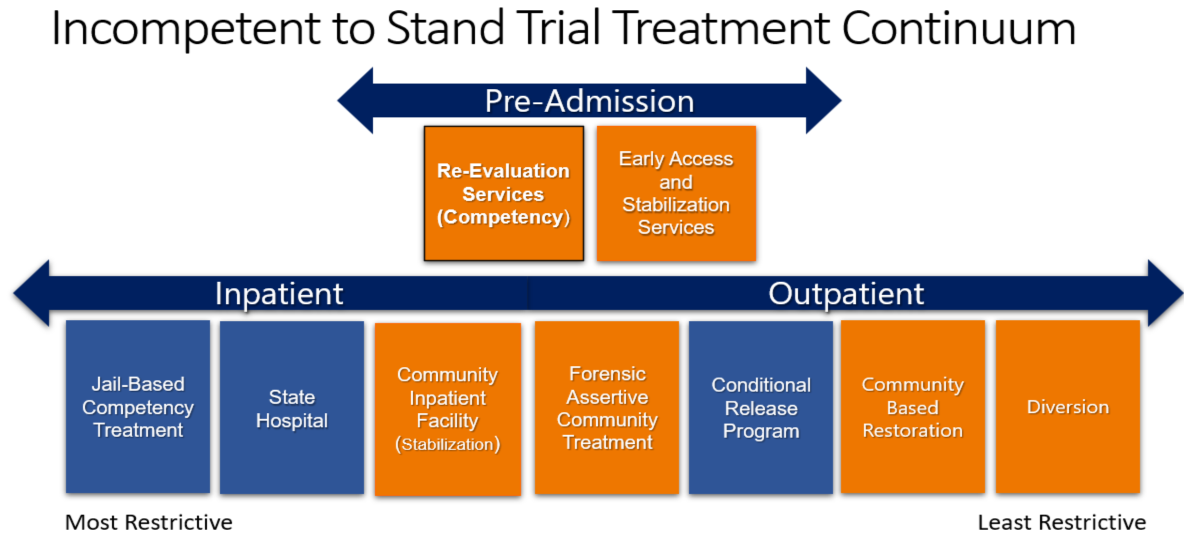
DSH Treatment Continuum & Services

The diagram on the following page depicts the comprehensive continuum of IST services DSH has established and is continuing to build with the recent Budget Act investments. Blue boxes indicate DSH legacy programs which have been part of DSH's continuum for a decade or more, while orange boxes represent newer service options which began implementation in recent years.

Historically, restoration treatment options for individuals deemed IST on felony charges were primarily provided in State Hospitals and Jail Based Competency Treatment (JBCT) programs. In 2018, DSH was authorized to partner with counties to pilot Felony Mental Health Diversion (Diversion) opportunities for individuals deemed IST on felony charges or who were likely to be found IST on felony charges. Additionally, in 2018 DSH was authorized to partner with Los Angeles (LA) County to establish the first community-based restoration of competency program for individuals from LA County who were determined to be IST on felony charges. Utilizing

[2] PC 1372 (a)(3)(C) states, "In all cases, the patient shall be returned to the committing court no later than 10 days following the filing of a certificate of restoration. The state shall only pay for 10 hospital days for patients following the filing of a certificate of restoration of competency. The State Department of State Hospitals shall report to the fiscal and appropriate policy committees of the Legislature on an annual basis in February, on the number of days that exceed the 10-day limit prescribed in this subparagraph. This report shall include, but not be limited to, a data sheet that itemizes by county the number of days that exceed this 10-day limit during the preceding year."

the recent investments made in the Budget Acts of 2021 and 2022, DSH is building upon these initial community-based programs to expand the treatment continuum serving ISTs in the least restrictive community treatment options.



Programs

The following are DSH's IST programs and services, and their corresponding descriptions:

DSH IST Treatment Programs	
Jail Based Competency Program (JBCT)	DSH contracts with a number of California counties, through the local Sheriffs' Offices, to provide restoration of competency services to felony IST patients housed in county jail facilities. These services are provided by the county's chosen mental health provider. The JBCTs are responsible for assessment for competency and malingering, cognitive screenings, re-assessment of competency, and completion and submission of all court reports. Services provided to IST patients include daily clinical contact, group and individual therapy, competency education materials, and clinical support through interdisciplinary teams.
State Hospitals (SH)	DSH's inpatient mental health hospital system provides clinical, medical, and competency restoration treatment

	services to IST defendants housed at Atascadero, Metropolitan, Napa, and Patton State Hospitals.
Community Inpatient Facility (CIF)	DSH's Institutions for Mental Diseases (IMDs)/Sub-Acute program contracts with community-based locked, inpatient facilities including IMDs, Mental Health Rehabilitation Centers, and acute psychiatric hospitals where individuals deemed incompetent to stand trial receive substantive services in lieu of admission to a State Hospital or JBCT program.
Forensic Assertive Community Treatment (FACT)	FACT Program services are available 24/7 through a mobile treatment team who provides onsite intensive wrap-around services, where the clients live, including psychiatry/medication management, individual and group treatment, as well as case management services and also respond to clients as needed to reduce the likelihood of rehospitalization through de-escalation and crisis intervention practices. DSH has contracted with a provider for minimum of 90 dedicated beds and staff resources for this new treatment option.
Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community. CONREP serves felony incompetent to stand trial patients who have been court-approved for outpatient placement in lieu of State Hospital placement.
Community Based Restoration (CBR)	DSH contracts with counties to operate Community Based Restoration programs where felony IST defendants from the contracted county can receive competency restoration services in a community treatment setting in lieu of a State Hospital or JBCT program.
Diversion	DSH Mental Health Diversion contracts with county-operated programs that allow felony IST defendants with certain serious mental illnesses to participate in intensive community-based mental health treatment. Services

	include housing, wrap-around support services, and medical evaluation and management with the goal of long-term mental health treatment engagement and connection to services. Criminal charges may bedropped for individuals who successfully complete the program. Participating counties are required to connect individuals who successfully complete this program into ongoing community mental health care programs.
DSH IST Services	
DSH Re-Evaluation Services	DSH's Re-Evaluation Program (WIC 4335.2) utilizes expert forensic evaluators to re-evaluate an IST defendant's competency status after the individual has been ordered to DSH while they are pending admission to a DSH IST Program and to determine if the individual needs to continue into an IST treatment program or is competent or has no substantial likelihood to be restored and should be returned to court. If at the time of the evaluation the individual appears to be a candidate for Diversion or outpatient treatment, it makes the recommendation for this consideration.
Early Access and Stabilization Services (EASS)	DSH contracts with county and private providers to provide substantive services including mental health services, psychiatric stabilization, and competency restoration services to felony IST defendants while the individual is in jail pending placement to a State Hospital, Jail Based Competency Program, Diversion or Community Based Program or facility.

The focus of treatment for the IST population is stabilization and restoration of competency.

- Stabilization: Stabilization focuses on medication evaluation and management, including a minimum of monthly visits with program psychiatrists, support with long-acting injectable medication, and daily contact with program staff.

- Restoration of Competence: Restoration treatment includes group psychoeducation, individual therapy, medication evaluation and management, and statutorily required competency to stand trial progress reports that can include a 90-Day, 180-day, etc. status update as well as PC1372 or unlikely to restore court reports.

Throughout treatment, patients are regularly evaluated and, if there is concurrence that a patient is competent, a forensic report (certificate of restoration) is sent to the court, identifying that the patient is competent and ready to be discharged to the county of commitment where they can resume trial proceedings. Patients must be discharged and returned to the custody of the county of commitment within 10 days of the certificate of restoration filing.

Population Data

System-wide Metrics

In fiscal year (FY) 2022-23, DSH treated 7,618 patients designated as IST. This growth of 29 percent from prior year, reflects DSH's continuum of care expansion of inpatient and outpatient programs, and a focus of growing census while balancing continued health and safety measures associated with COVID-19. DSH had an average daily census of 2,647 IST patients during FY 2022-23 with a 32 percent growth from 2,219 IST designated patients in July 2022, to 2,938 in June 2023. In addition, compared to prior fiscal year, average daily census increased overall by 32 percent in FY 2022-23. The table below summarizes key statistics across the IST population.

Table 1: System-wide IST Patient Data Summary[3]

IST Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	4,979	5,850	17%
Patient Admissions	3,946	5,874	49%
Patients Served	5,919	7,618	29%
Average Daily Census	2,011	2,647	32%

In FY 2022-23 5,850 IST patients were committed to DSH for competency treatment, an increase of 17 percent from FY 2021-22. Chart 1 displays IST system-wide referrals and admissions for FY 2022-23. Chart 2 displays a five-year period of referrals and admissions, also identifying DSH's increasing number of patients treated annually over the past few years.

[3] Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

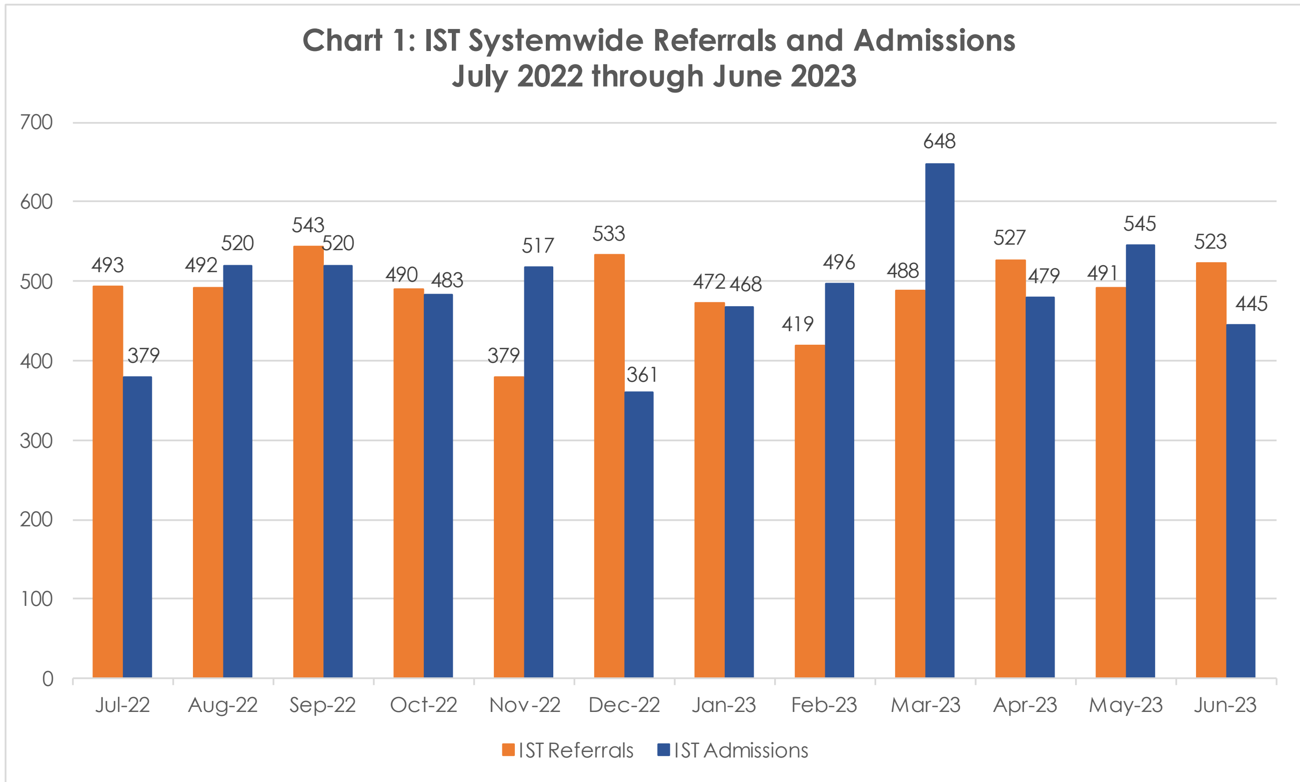


Chart 1: IST Systemwide Referrals and Admissions
July 2022 through June 2023
700
600
500
400
300
200
100
0
493
379
492
520
543
520
490
483
379
517
533
361
472
468
419
496
488
648
527
479
491
545
523
445
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
IST Referrals
IST Admissions

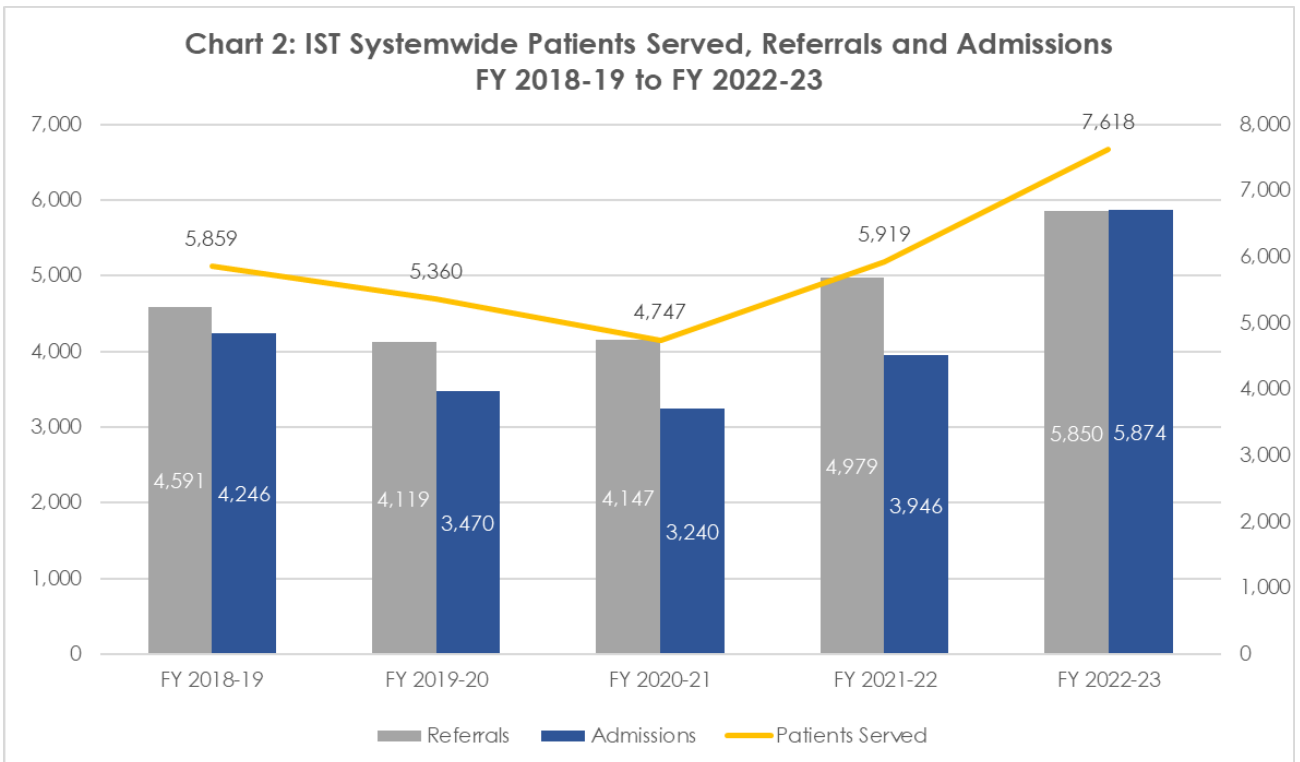


Chart 2: IST Systemwide Patients Served, Referrals and Admissions
FY 2018-19 to FY 2022-23
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
5,859
5,360
4,747
5,919
7,618
4,591
4,246
4,119
3,470
4,147
3,240
4,979
3,946
5,850
5,874
FY 2018-19
FY 2019-20
FY 2020-21
FY 2021-22
FY 2022-23
Referrals
Admissions
Patients Served

In FY 2022-23, the IST PPL decreased by 48 percent from 1,718 patients in July 2022 to 894 patients in June 2023. The primary drivers in reducing the IST PPL have included, expansion of bed capacity, admission rates to inpatient and outpatient programs and patients found competent prior to admission through a re-evaluation of competency while in county jail. The table below, Table 2, identifies the IST pending placement list as of June 30 of the corresponding year.

Table 2: IST System-wide Pending Placement List

IST Patients Pending Placement	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	849	1,212	1,454	1,779	894

Inpatient Program Metrics

DSH inpatient treatment programs include State Hospitals, JBCT, and Community Inpatient Facilities (CIF). During FY 2022-23 DSH inpatient programs treated on average 1,978 IST patients. July 2022 IST patient average census was 1,603 with a 38 percent growth to 2,209 IST patients in June 2023.

Table 3: IST Inpatient Data Summary[4]

IST Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	3,449	5,253	52%
Patients Served	5,030	6,412	27%
Average Daily Census	1,534	1,978	29%

DSH inpatient programs admitted 5,253 IST patients in FY 2022-23 with an average of 438 admissions per month. Chart 3 displays inpatient program IST admissions by quarter and the average monthly admissions rate.

[4] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

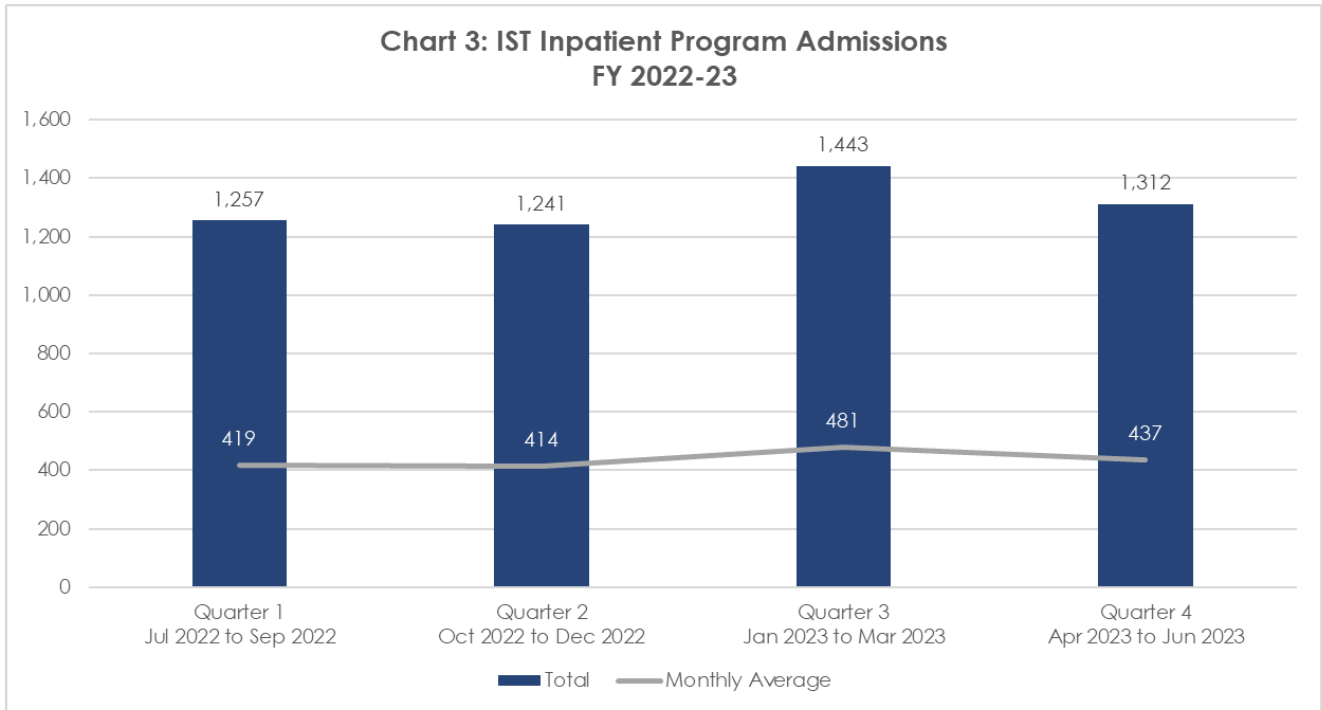


Table 4, below, displays the number of IST patients treated across the year in inpatient programs for the past five years.

Table 4: IST Patients Served – Inpatient Programs[5]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	5,694	5,090	4,241	5,030	6,412

Inpatient Discharge Data

DSH discharged 4,628 IST patients from inpatient programs with an average length of stay of 134 days and a median length of stay of 107 days across all programs. Forty percent of IST patients discharged within the first 90 days of their stay, 77 percent of the IST patients discharged within the first 180 days of their stay, and 95 percent of the IST patients discharged within the first year of their stay.

[5] Patients served excludes other inpatient and outpatient program transfers.

Table 5: IST Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 90 Days	40%
91 - 180 Days	37%
181 - 365 days	18%
366 - 730 days (1 - 2 years)	5%
731+ days (2+ years)	0%

For patients yet to discharge the average days in treatment is 131.4 days and the median days in treatment is 106 days. Table 6 displays Inpatient programs length of stay by quarter.

Table 6: IST Inpatient Length of Stay by Quarter – FY 2022-23

IST Inpatient Programs: Length of Stay	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
Average Length of Stay	132.1	135.1	138.6	130.8	134.0
Median Length of Stay	101.0	106.0	119.0	104.0	107.0
Discharged Count	1,097	1,000	1,184	1,347	4,628

Outpatient Program Metrics

DSH outpatient treatment programs include CONREP, Community Based Restoration (CBR), and Diversion. During FY 2022-23, DSH outpatient programs treated on average 668 IST patients. In July 2022 the IST patient average census was 615 with an 18 percent growth to 729 IST patients by the end of the FY in June 2023.

Table 7: IST Outpatient Data Summary[6]

IST Outpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	497	621	25%
Patients Served	889	1,206	36%
Average Daily Census	476	668	40%

DSH outpatient programs admitted 621 IST patients in FY 2022-23 with an average of 52 admissions per month. Chart 4 displays IST outpatient program admissions by quarter.

[6] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

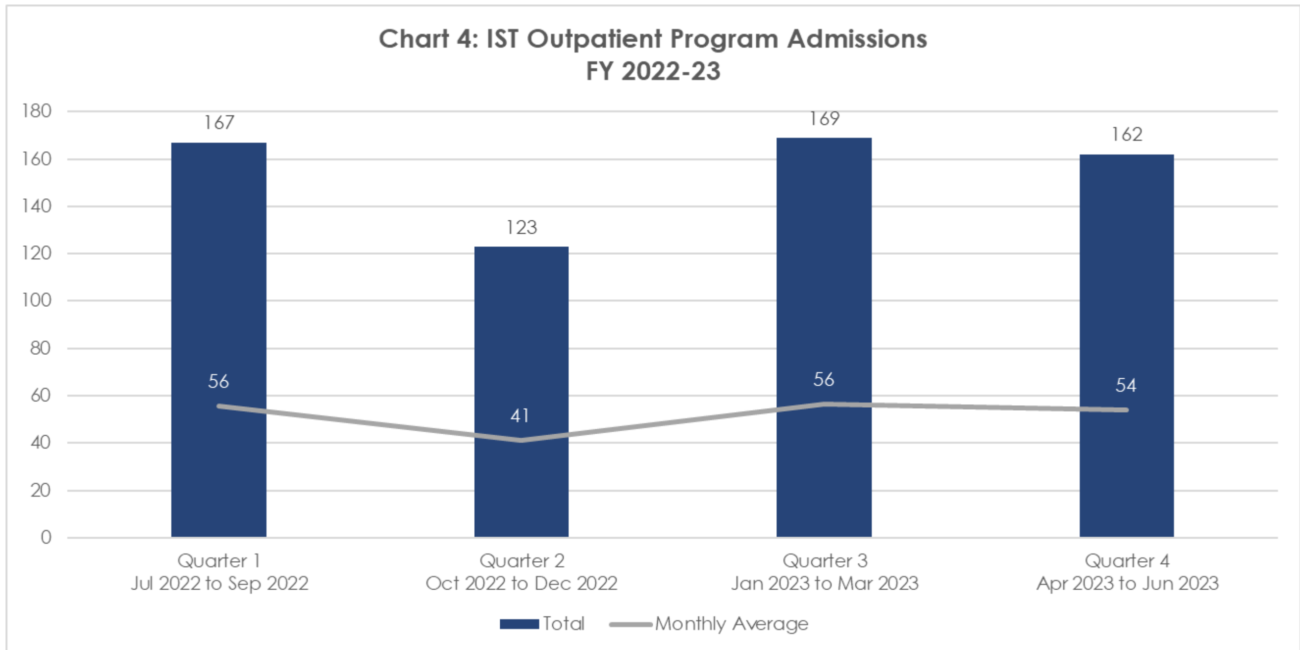


Table 8, below, displays the number of patients treated in outpatient programs within each FY for the past five years.

Table 8: IST Patients Served – Outpatient Programs[7]

Patients Treated/Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	165	270	506	889	1,206

Outpatient Discharge Data

DSH discharged 455 IST patients from outpatient programs with an average length of stay of 409.7 days and a median length of stay of 466 days across all programs. Sixteen percent of IST patients discharged within the first 90 days of their stay, 30 percent of the IST patients discharged within the first 180 days of their stay, and 45 percent of the IST patients discharged within the first year of their stay.

Table 9: IST Outpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 90 Days	16%
91 - 180 Days	14%
181 - 365 days	15%
366 - 730 days (1 - 2 years)	52%
731+ days (2+ years)	3%

[7] Patients served excludes other inpatient and outpatient program transfers.

Table 10 displays outpatient length of stay by quarter.

Table 10: IST Outpatient Length of Stay by Quarter – FY 2022-23

IST Outpatient Programs: Length of Stay	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
Average Length of Stay	354.8	409.8	432.4	418.7	409.7
Median Length of Stay	227.0	508.0	494.0	480.0	466.0
Discharged Count	77	110	129	139	455

IST Services Metrics

Early Access Stabilization Services

During FY 2022-23, DSH's Early Access Stabilization Services (EASS) Program enrolled over 1,400 IST patients with 36 counties actively participating in EASS. The EASS program provided IST services to 1,427 patients during the FY.

Table 11: IST Early Access Stabilization Services Summary by Quarter

IST Early Access Stabilization Services	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
IST Substantive Services Initiated	115	392	466	454	1,427
Newly Participating Counties	12	14	5	5	36

Re-Evaluation Services

IST Re-Evaluation Services completed 2,143 evaluations during FY 2022-23. Outcomes resulted in 25 percent ISTs found competent prior to admission, 74 percent retain and treat, and less than one percent IST unlikely to restore.

Table 12: IST Re-Evaluation Services Summary by Quarter[8]

IST Re-Evaluation Services	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
IST Evaluations Completed	**568**	**607**	**537**	**431**	**2,143**
IST Found Competent	28%	25%	26%	21%	25%
IST Retain and Treat	***%	75%	***%	79%	74%
IST Unlikely to Restore	***%	0.0%	***%	0.0%	<1%

[8] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

POPULATION PROFILE
Lanterman-Petris-Short Patients

Description of Legal Class

The Lanterman-Petris-Short (LPS) population includes multiple civil commitment types of patients who have been admitted under the LPS Act. These patients require physically secure 24-hour care and are committed through civil court proceedings if legal criteria concerning a danger to themselves or others, or grave disability, are met. Certain current parolees or former parolees may also be conserved under LPS commitments. It is also possible for other forensic commitments to convert to LPS commitments, such as if a patient committed as Incompetent to Stand Trial (IST) is found substantially unlikely to regain competence in the foreseeable future but requires ongoing mental health inpatient treatment and the respective county pursues legal conservatorship.

Legal Statutes and Commitments[1]

- PC 2974 – Parolee from CDCR
- WIC 5353 – Temporary Conservatorship
- WIC 5358 – Conservatorship
- WIC 5008(h)(1)(B) – Murphy Conservatee
- WIC 5304(a) – 180-Day Post Certification
- WIC 6000 – Voluntary
- WIC 4825, 6000(a) – Admission to a state hospital of a developmentally disabled individual by their conservator
- WIC 6500, 6509 – A person with a developmental disability committed to a state hospital

Requirements for Discharge

LPS conservatees have not been charged with a crime but are instead referred by local community mental health programs through involuntary civil commitment procedures pursuant to the LPS Act. Those whose psychiatric conditions require a higher level of care and cannot be treated in locked facilities or board and care homes are sent to DSH for treatment. A patient's LPS conservatorship lasts for one year and can be renewed by the court on an annual basis. A new petition for renewal is filed with the court prior to the current conservatorship's expiration.

LPS patients are discharged from DSH when (1) their county of residence places them in a different facility, (2) their county of residence places them in independent living

[1] Legal Statute and Commitments List only includes those applicable to patients treated by DSH in the past five years. Other LPS Act related legal statutes and commitments not typically treated by DSH include WIC 5304(b), WIC 5150, WIC 5250, WIC 5260, WIC 5270.15, WIC 5303, WIC 6506, and WIC 6552.

or with family, or (3) they have successfully petitioned the court to remove the conservatorship.

DSH Treatment Continuum & Services

Under Welfare and Institutions Code (WIC) section 5150, an individual, on probable cause, can be taken into custody for mental health treatment for 72 hours. The individual can then be evaluated for an additional 14-day period of treatment pursuant to WIC 5250. After further evaluation and judicial review, the individual can then be placed on hold or temporarily conserved (T.Cons) for up to 30 days pending a full commitment hearing under WIC 5353 or WIC 5270. If the individual is gravely disabled, they can be placed under conservatorship pursuant to WIC 5350 for one year.

Over the past five years, 85 percent of all LPS patients treated in DSH were committed under a WIC 5353 or 5358 conservatorship. Table 1 below displays the percent of LPS patients treated in DSH over the past five years by commitment type.

Table 1: LPS Patients Treated by Commitment Type

Commitment Type	Percent of LPS Patients Treated (Past 5 years)
WIC 5353 - Temporary Conservatorship WIC 5358 - Conservatorship	85%
WIC 5008(h)(1)(B) - Murphy Conservatorship	14%
WIC 6000 - Voluntary	0.25%
PC 2974 - Parolee from CDCR	0.25%
Other LPS	0.17%

The focus of treatment for the LPS population is on psychiatric stabilization and psychosocial treatments to reduce the risk of danger to themselves or others and develop basic life skills to function optimally in a lower level of care in the community. Because of the wide diversity of patients under the LPS commitment, discharge criteria differ for each legal statute. Most LPS patients can be treated in the community once the DSH treatment team believes the patient is no longer a danger to themselves or others and the patient's county of residence pursues alternative placement options.

Programs

DSH provides inpatient treatment to LPS patients within the State Hospitals.

DSH LPS Treatment Programs

State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals.

Population Data

System-wide Metrics

In fiscal year (FY) 2022-23, DSH experienced a decrease in the total number of LPS patients treated and in the LPS average daily census, but an increase in LPS referrals and admissions as compared to the prior year. These statistics are summarized in Table 2 below.

Table 2: LPS Patient Data Summary[2]

LPS Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	112	135	21%
Patient Admissions	36	94	161%
Patients Served	835	736	-12%
Average Daily Census	770	637	-17%
Average Length of Stay	1,779	2,353	32%
Patient Discharges	228	245	7%

Even with the increase in admissions, the LPS census decreased by 17 percent within FY 2022-23 from 707 patients in July 2022 to 590 patients in June 2023[3].

Chart 1 displays LPS system-wide referrals and admissions by quarter for FY 2022-23, and Chart 2 displays a five-year period of referrals and admissions for a broader historical view.

[2] Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient program transfers. Patients served excludes other inpatient program transfers.
[3] DSH provides treatment to patients pursuant to the LPS Act through a Memorandum of Understanding (MOU) with California Counties via the California Mental Health Services Authority (CalMHSA), to provide a maximum of 556 treatment beds.

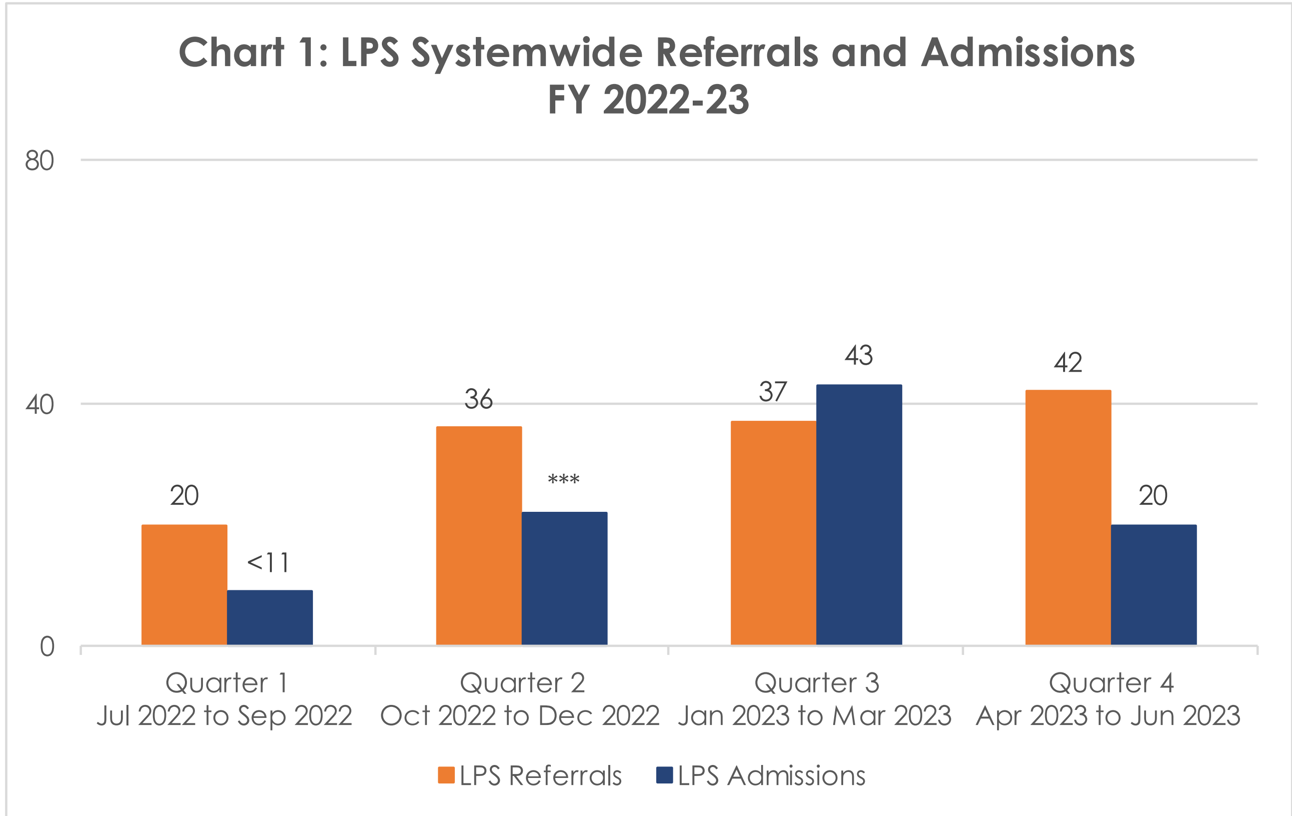


Chart 1: LPS Systemwide Referrals and Admissions
FY 2022-23
80
40
0
20
<11
36
***
37
43
42
20
Quarter 1
Jul 2022 to Sep 2022
Quarter 2
Oct 2022 to Dec 2022
Quarter 3
Jan 2023 to Mar 2023
Quarter 4
Apr 2023 to Jun 2023
LPS Referrals
LPS Admissions

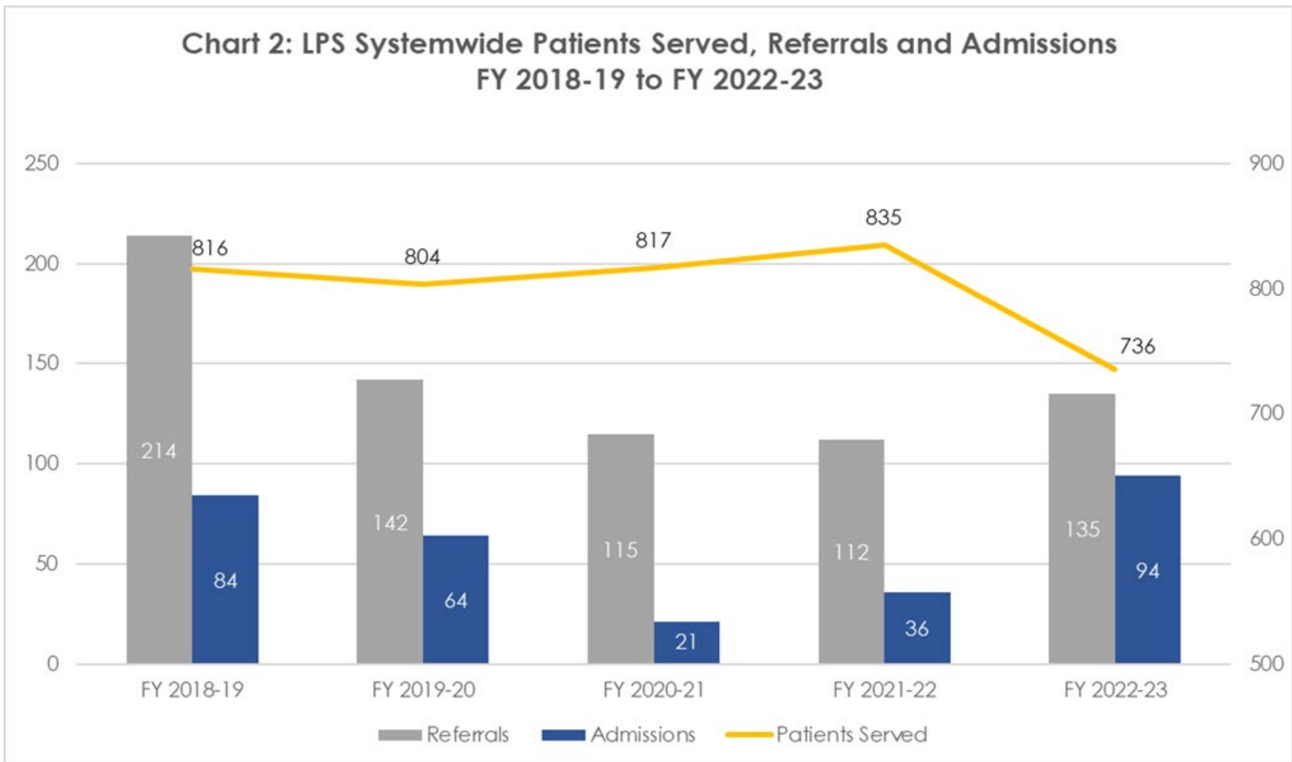


Chart 2: LPS Systemwide Patients Served, Referrals and Admissions
FY 2018-19 to FY 2022-23
250
200
150
100
50
0
900
800
700
600
500
214
84
816
142
64
804
115
21
817
112
36
835
135
94
736
FY 2018-19
FY 2019-20
FY 2020-21
FY 2021-22
FY 2022-23
Referrals
Admissions
Patients Served

DSH is not statutorily required to admit LPS patients as is the case with other legal classifications but complies with a Memorandum of Understanding (MOU) agreed upon with the counties for 556 LPS beds. All conservatorships under the LPS Act must designate a least restrictive placement based on the individual's treatment needs. DSH is one of many placement options designated in the statute. Therefore, admission of an LPS conservatee to a state hospital is reserved for those that are deemed to require a DSH setting for treatment. LPS patients referred and committed to DSH are added to the DSH System-wide LPS Pending Placement List until a bed becomes available or a DSH bed is no longer needed. Table 3 below identifies the number of LPS patients pending placement into a DSH bed as of June 30th of the corresponding year. The number of LPS patients pending placement remained relatively consistent at a two percent decrease from FY 2021-22 to FY 2022-23.

Table 3: LPS System-wide Pending Placement List

LPS Patients Pending Placement	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	216	201	297	317	311

Discharge Data

DSH discharged 245 LPS patients in FY 2022-23 with an average length of stay of 2,353.4 days (6.4 years) and a median length of stay of 1,650 days (4.5 years). Only six percent of LPS patients discharged within one year, 55 percent discharged within five years, and 46 percent had a length of stay longer than five years. Table 4 below depicts the distribution of LPS patients discharged in FY 2022-23 by length of stay.

Table 4: LPS Patient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	6%
366 - 1,460 Days (2 - 4 years)	39%
1,461 - 1,825 days (4 - 5 years)	10%
1,826 - 3,650 days (5 - 10 years)	28%
3,651+ days (10+ years)	18%

For patients yet to discharge the average days in treatment is 588 days and median days in treatment is 1,844.5 (5.1 years).

Table 5 on the following page displays length of stay by quarter for FY 2022-23.

Table 5: LPS Patient Length of Stay by Quarter – FY 2022-23

LPS Patient Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	2,156.4 (5.9 yrs.)	2,123.7 (5.8 yrs.)	2,928.5 (8.0 yrs.)	1,948.9 (5.3 yrs.)	2,353.4 (6.4 yrs.)
Median Length of Stay	1,721.0 (4.7 yrs.)	1,577.0 (4.3 yrs.)	2,042.0 (5.6 yrs.)	1,268.5 (3.5 yrs.)	1,650.0 (4.5 yrs.)
Discharged Count	61	63	77	44	245

LPS patients can be discharged to a variety of locations. For the 245 LPS patients discharged in FY 2022-23 those locations are displayed in the table below.

Table 6: LPS Patient Discharges by Location

Discharge Location	**LPS** FY 2022-23	**MURCON** FY 2022-23	**Total FY 2022-23**	**Percent to Total**
Community Outpatient Treatment	<11	0	**<11**	***%
Deceased	23	0	**23**	9%
Discharged to Community	***	<11	**85**	35%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	***	***	**73**	30%
Locked Medical Facility	***	<11	**48**	20%
Other/Unknown	<11	0	**<11**	***%
Total Discharges	**229**	**16**	**245**	**100%**

POPULATION PROFILE
Not Guilty by Reason of Insanity Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits individuals found Not Guilty by Reason of Insanity (NGI) under Penal Code (PC) 1026: Pleadings and Proceedings before Trial-Plea. Once a court determines that an individual (defendant) is found guilty but was insane at the time the crime was committed, the court commits the defendant to DSH for a maximum term of commitment equal to the longest sentence which could have been imposed for the crime. Based on the criminal conviction, the patient is found not guilty by reason of insanity. A patient may be placed immediately in outpatient treatment in the community under supervision rather than going directly to a state hospital. The court can recommit the patient to DSH beyond the maximum term of the original commitment if the patient is found, based on his or her mental illness, to represent a substantial danger of physical harm to others. A recommitment lasts for two years from the date of the recommitment order.

Legal Statutes and Commitments

- PC 1026 – Not Guilty by Reason of Insanity
- PC 1026.5 – Not Guilty by Reason of Insanity, Extension of term
- PC 1610 – Temporary admission while waiting for court revocation of PC 1026, RONGI
- WIC 702.3 - Minor Not Guilty by Reason of Insanity, MNGI

Requirements for Discharge

Restoration of sanity is a two-step process in which evidence is presented and reviewed that would determine if a patient is a danger to the health and safety of others, due to his or her mental illness, if released under supervision and treatment in the community. The two-step process requires (1) an outpatient placement hearing and (2) a restoration hearing following a year in outpatient care. During the first step of the process the court must find that the patient is no longer a danger to the health and safety of others due to his or her illness if released under supervision and treatment in the community. During the second step of the process, the court must determine whether the patient has been fully restored to sanity. The court's finding of restoration will result in the patient's unconditional release from supervision. A patient may bypass the mandatory one-year of outpatient commitment and have an early restoration hearing in the event the conditional release program director recommends an early release. Outpatient status may not exceed one year, after

which time the Court must either discharge the patient, order the patient confined to a facility, or renew the outpatient status.[1]

DSH Treatment Continuum & Services

Because NGI patients tend to have severe mental illnesses and their crimes may involve severe violence, their length of treatment in a state hospital may be longer. The treatment team must demonstrate to the court that the NGI patient has achieved long-term stabilization and no longer poses a danger due to their mental illness. Thus, the patient needs to demonstrate long-term symptom stability, long-term adherence to psychiatric treatments, and an understanding of the factors that exacerbate their mental illness. Each NGI patient's progress in treatment is assessed by a forensic evaluator every six months with progress reports submitted to the court. In the event that the individual's maximum term of commitment approaches and DSH does not believe the individual is safe to discharge, DSH can pursue an extension of the NGI commitment to extend the individual's stay in the DSH hospital, pursuant to PC 1026.5. In fiscal year (FY) 2022-23, 379 patients were served at the state hospitals under this extension option.

To assess dangerousness and develop effective treatments to reduce violence risk, specialized violence risk assessments must be conducted. Based on the individual NGI patient's mental illness factors and violence risk, individualized treatments must be developed. Additionally, scenarios that could realistically provoke similar violent responses must be evaluated and worked through with the patient. Furthermore, the patient must understand their violence risk factors and be able to demonstrate that they would take preventive actions to mitigate any factors that would heighten their violence risk.

Although NGI patients are admitted to DSH because of a severe mental illness and dangerousness, NGI patients have the right to refuse treatment unless that right is removed by case law or regulation, as guided by the *Greenshields* involuntary medication order process. This can effectively lengthen the patient stay at the state hospital if they choose not to fully participate in the treatments recommended by their treatment team.

Programs

DSH provides treatment to NGI patients through inpatient care within the State Hospitals and on an outpatient basis through the Forensic Conditional Release Program (CONREP).

[1] Penal Code section 1606

DSH NGI Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals.
Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community.

Population Data

System-wide Metrics

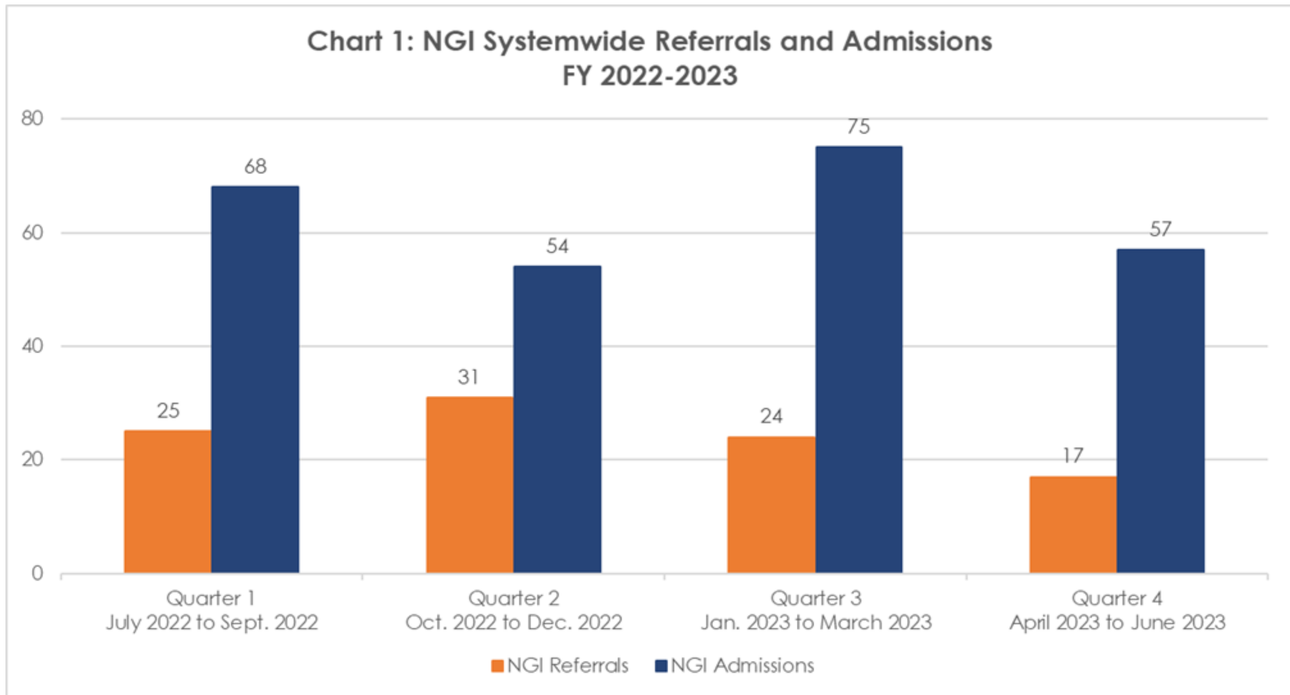
Across inpatient and outpatient programs, DSH treated 1,832 patients designated as NGI in FY 2022-23. The table below summarizes key statistics across the NGI population.

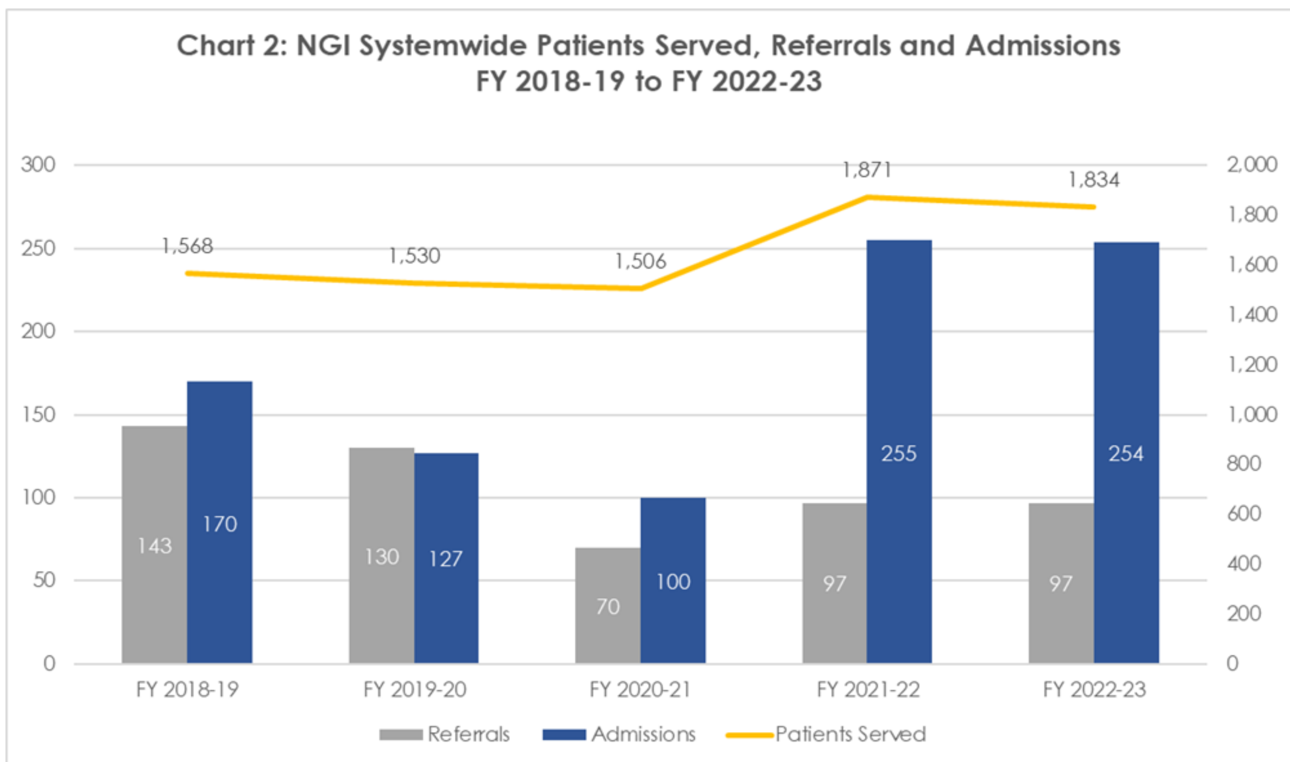
Table 1: System-wide NGI Patient Data Summary[2]

NGI Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	97	97	0%
Patient Admissions	255	254	0%
Patients Served	1,869	1,832	-2%
Average Daily Census	1,759	1,705	-3%

Chart 1 displays NGI system-wide referrals and admissions by quarter for FY 2022-23 and Chart 2 displays a five-year period of referrals and admissions for a broader historical view[3].

[2] Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.
[3] Outpatient data is only included in FY 2021-22 and FY 2022-23 (Chart 2).





NGI patients are individuals committed to a state hospital for treatment by the courts and transfer directly from jail. The table below, Table 2, identifies the NGI pending placement list (PPL) as of June 30 of the corresponding year.

Table 2: NGI System-wide Pending Placement List[4]

NGI Patients Pending Placement	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	29	34	14	44	11

Inpatient Program Metrics

Patients committed to DSH as NGI receive inpatient treatment within four of DSH's state hospitals: DSH-Atascadero, DSH-Metropolitan, DSH-Napa and DSH-Patton. During FY 2022-23, DSH inpatient programs treated on average 1,228 NGI patients daily, with an average census of 1,241 in July 2022, with a slight decrease of one percent across the year ending with an average census of 1,228 NGI patients in June 2023.

Table 3: NGI Inpatient Data Summary[5]

NGI Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	149	149	0%
Patients Served	1,406	1,348	-4%
Average Daily Census	1,290	1,228	-5%

DSH Inpatient programs admitted 149 NGI Patients in FY 2022-23 with an average of 12 admissions per month. Chart 3 displays Inpatient program NGI admissions by quarter and the average monthly admissions rate.

[4] The pending placement list reflects patients pending inpatient treatment.

[5] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

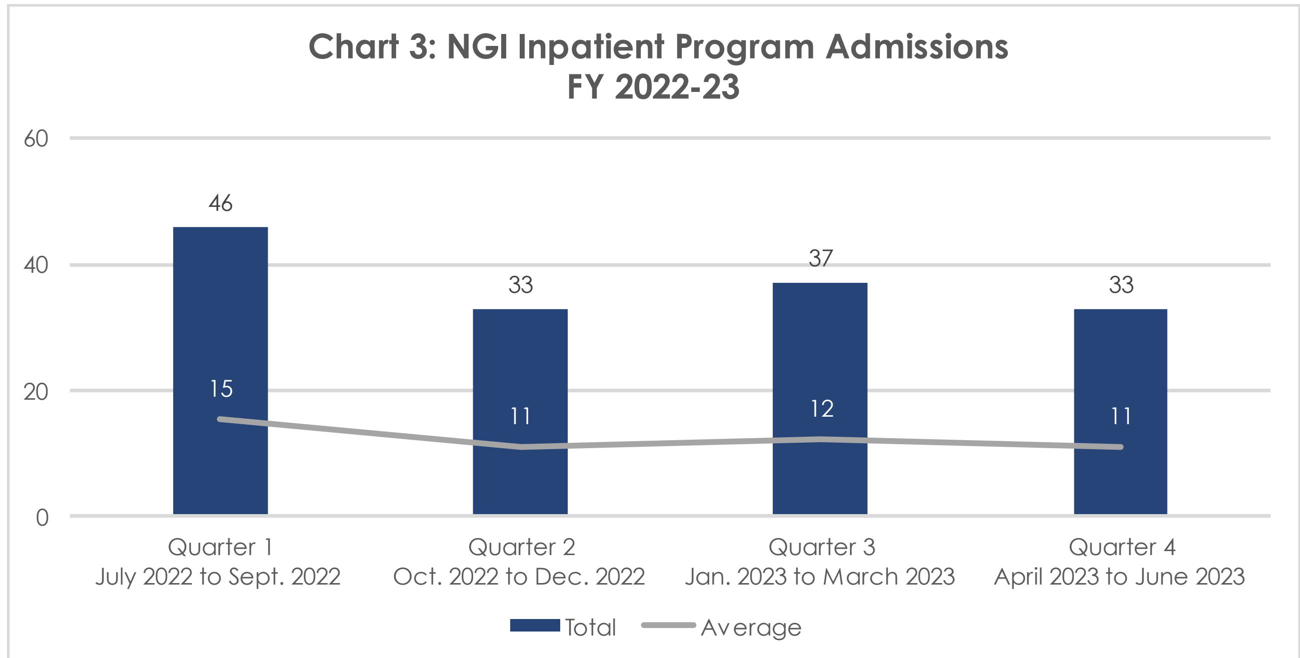


Table 4, below, displays the number of NGI patients treated in inpatient programs within each FY for the past five years.

Table 4: NGI Patients Served – Inpatient Programs[6]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	1,568	1,530	1,506	1,406	1,348

Inpatient Discharge Data

DSH discharged 165 NGI patients from inpatient programs with an average length of stay of 3,045.1 days (over 8 years) and a median length of stay of 2,122.0 days (over 5 years) across all programs. Only 12 percent of the NGI patients discharged within the first year of their stay, 44 percent of the NGI patients discharged within the first five years of their stay, and 56 percent of the NGI patients discharged with a length of stay of more than five years. Table 5 on the following page depicts the distribution of NGI patients discharged from inpatient programs in FY 2022-23 by length of stay.

[6] Patients served excludes other inpatient and outpatient program transfers.

Table 5: NGI Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	12%
366 - 1,460 Days (2 - 4 years)	21%
1,461 - 1,825 days (4 - 5 years)	11%
1,826 - 3,650 days (5 - 10 years)	27%
3,651+ days (10+ years)	28%

For patients yet to discharge the average days in treatment is 4,043.7 days (11.1 years) and median days in treatment is 2,668.0 days (7.3 years).

Table 6 displays Inpatient programs length of stay by quarter.

Table 6: NGI Inpatient Length of Stay by Quarter – FY 2022-23

NGI Inpatient Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	3,426.7 (9.4 yrs.)	3,545.0 (9.7 yrs.)	2,744.3 (7.5 yrs.)	2,116.0 (5.8 yrs.)	3,045.1 (8.3 yrs.)
Median Length of Stay	2,285.0 (6.3 yrs.)	2,670.0 (7.3 yrs.)	1,944.0 (5.3 yrs.)	1,695.0 (4.6 yrs.)	2,122.0 (5.8 yrs.)
Discharged Count	52	42	40	31	165

NGI patients can be discharged to a variety of locations including outpatient treatment programs. The table below displays the discharge locations for the 165 patients discharged in FY 2022-23.

Table 7: NGI Inpatient Discharges by Location

NGI Inpatient Discharge Location	**NGI** FY 2022-23	**Percent to Total**
Community Outpatient Treatment	69	42%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	52	32%
Discharged to Community	25	15%
Deceased	19	12%
Total Discharges	**165**	**100%**

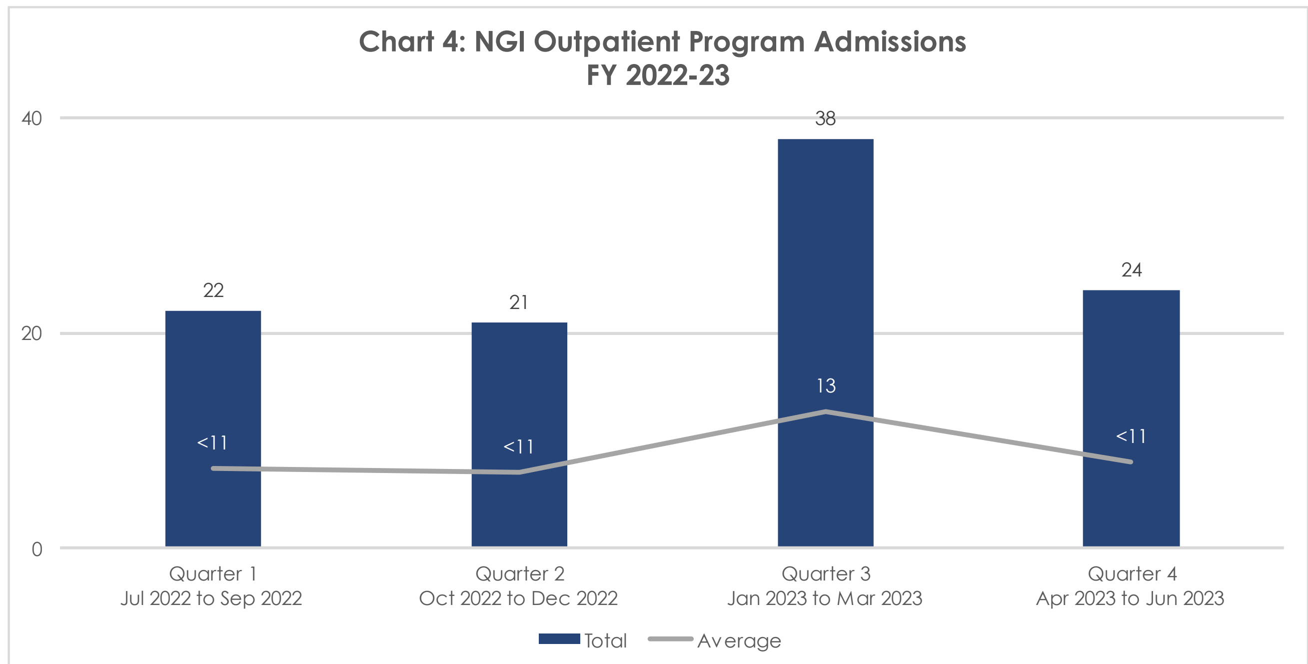
Outpatient Program Metrics

CONREP is the DSH outpatient treatment program for patients committed as NGI. During FY 2022-23, DSH CONREP treated on average 478 NGI patients daily, with an average census of 483 in July 2022 and an ending average census of 469 patients in June 2023.

Table 8: NGI Outpatient Data Summary[7]

NGI Outpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	106	105	-1%
Patients Served	463	484	5%
Average Daily Census	468	478	2%

DSH outpatient programs admitted 105 NGI patients in FY 2022-23 with an average of nine admissions per month. Chart 4 displays outpatient program NGI admissions by quarter.



[7] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

The table below displays the number of patients treated across the year in outpatient programs.

Table 9: NGI Patients Served – Outpatient Programs[8]

Patients Treated/Served	FY 2021-22	FY 2022-23
	465	486

Outpatient Discharge Data

DSH discharged 121 NGI patients from outpatient programs with an average length of stay of 1,797.3 days (approximately 5 years) and a median length of stay of 918.0 days (over 2 years) across all programs. Twenty-seven percent of NGI patients discharged within the first year of their stay, 50 percent of the NGI patients discharged within the first five years of their stay and 50 percent of the NGI patients discharged with a length of stay of more than five years. Table 10 below depicts the distribution of NGI patients discharged from outpatient programs in FY 2022-23 by length of stay.

Table 10: NGI Outpatient Length of Stay Distribution

NGI Outpatient Length of Stay	% of Patients
0 - 365 Days (1 year)	27%
366 - 1,460 Days (2 - 4 years)	8%
1,461 - 1,825 days (4 - 5 years)	14%
1,826 - 3,650 days (5 - 10 years)	14%
3,651+ days (10+ years)	36%

Table 11 displays outpatient length of stay by quarter for FY 2022-23.

Table 11: NGI Outpatient Length of Stay by Quarter – FY 2022-23

NGI Outpatient Length of Stay	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
Average Length of Stay	2,176.9 (6 yrs.)	2,499.8 (6.8 yrs.)	1,523.6 (4.2 yrs.)	1,126.2 (3.1 yrs.)	1,797.3 (4.9 yrs.)
Median Length of Stay	1,718.0 (4.7 yrs.)	1,157.0 (3.2 yrs.)	672.0 (1.8 yrs.)	643.0 (1.8 yrs.)	918.0 (2.5 yrs.)
Discharged Count	22	31	39	29	121

[8] Patients served excludes other inpatient and outpatient program transfers.

POPULATION PROFILE

Offenders with a Mental Health Disorder

Description of Legal Class

The Department of State Hospitals (DSH) admits Offenders with a Mental Health Disorder (OMD) patients under Penal Code (PC) 2962: Disposition of Mentally Disordered Prisoners upon Discharge. OMD commitments are patients who are parolees (or former parolees), referred by the California Department of Corrections and Rehabilitation (CDCR), who meet the six criteria for OMD classification. The criteria include (1) the presence of a severe mental disorder, (2) the mental disorder is not in remission or requires treatment to be kept in remission, (3) the mental disorder was a factor in the commitment offense, (4) the prisoner has been in treatment for at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury and (6) the prisoner continues to be dangerous due to the severe mental disorder. The individual is evaluated by both the treating CDCR psychologist/psychiatrist and a DSH psychologist/psychiatrist. If the evaluators agree the individual meets all the conditions above, the Board of Parole Hearings (BPH) can commit that individual to a state hospital as a condition of parole. The individual then receives treatment at DSH unless they can be certified for outpatient treatment or the individual challenges the commitment.

Parolees who committed one of a specified list of crimes and who were treated for a severe mental disorder connected to their original crime can be committed to a state hospital as a condition of parole for a period not to exceed the length of their parole term; these patients are committed under PC 2962. If the person still requires treatment at the end of their parole term, they can be committed under PC 2972 if it is determined that the patient has a severe mental disorder, that the patient's severe mental disorder is not in remission or cannot be kept in remission without treatment, and that by reason of their severe mental disorder, the patient represents a substantial danger of physical harm to others. A person committed under PC 2972 is committed for one year and re-evaluated annually.

Legal Statutes and Commitments

- PC 2962 – Parolee referred from CDCR
- PC 2964(a) – OMD Admission from Outpatient
- PC 2972 – OMD, commitment for further treatment
- PC 1610 – Temporary admission while waiting for court revocation of PC 2972
- PC 1610 – Temporary admission while waiting for court revocation of MDSO
- WIC 6316 – Person convicted of a sex offense ordered to treatment (former MDSO statute now repealed)

Requirements for Discharge

After one year, a parolee is entitled to an annual review hearing conducted by the BPH to determine if (1) the parolee still meets the six criteria for OMD classification and (2) whether the parolee can be treated on an outpatient basis. The length of a parole period is determined by statute and depends on the type of sentence imposed. Parole terms can extend beyond the maximum parole period due to revocation or escape attempts. A parole period can be waived at the discretion of BPH. Most parolees have a maximum parole period of three years, with a four-year maximum if parole was suspended due to revocation. The parole period may exceed four years for more serious offenses.

An OMD patient (or parolee) may be placed into outpatient treatment in the Forensic Conditional Release Program (CONREP) if the Court believes that the OMD patient can be safely and effectively treated on an outpatient basis. Outpatient status may not exceed one year, after which time the Court must either discharge the patient, order the patient confined to a facility, or renew the outpatient status.[1]

DSH Treatment Continuum & Services

The focus of treatment for the OMD population involves helping patients increase their ability to safely and effectively manage symptoms associated with their mental illness and prepare them for eventual transfer to outpatient treatment in CONREP. Another area of focus is substance abuse treatment since a history of substance abuse is prevalent in most OMD patients. Other goals are to motivate patients for treatment, develop greater self-autonomy and independence, and the mastery of self-discipline and Activities of Daily Living (ADL) skills such as practicing good hygiene, grooming, and feeding.

Programs

DSH provides treatment to OMD patients through inpatient care within State Hospitals and on an outpatient basis in CONREP.

DSH OMD Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals.

[1] Penal Code section 1606

Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community.

Population Data

State-wide Metrics

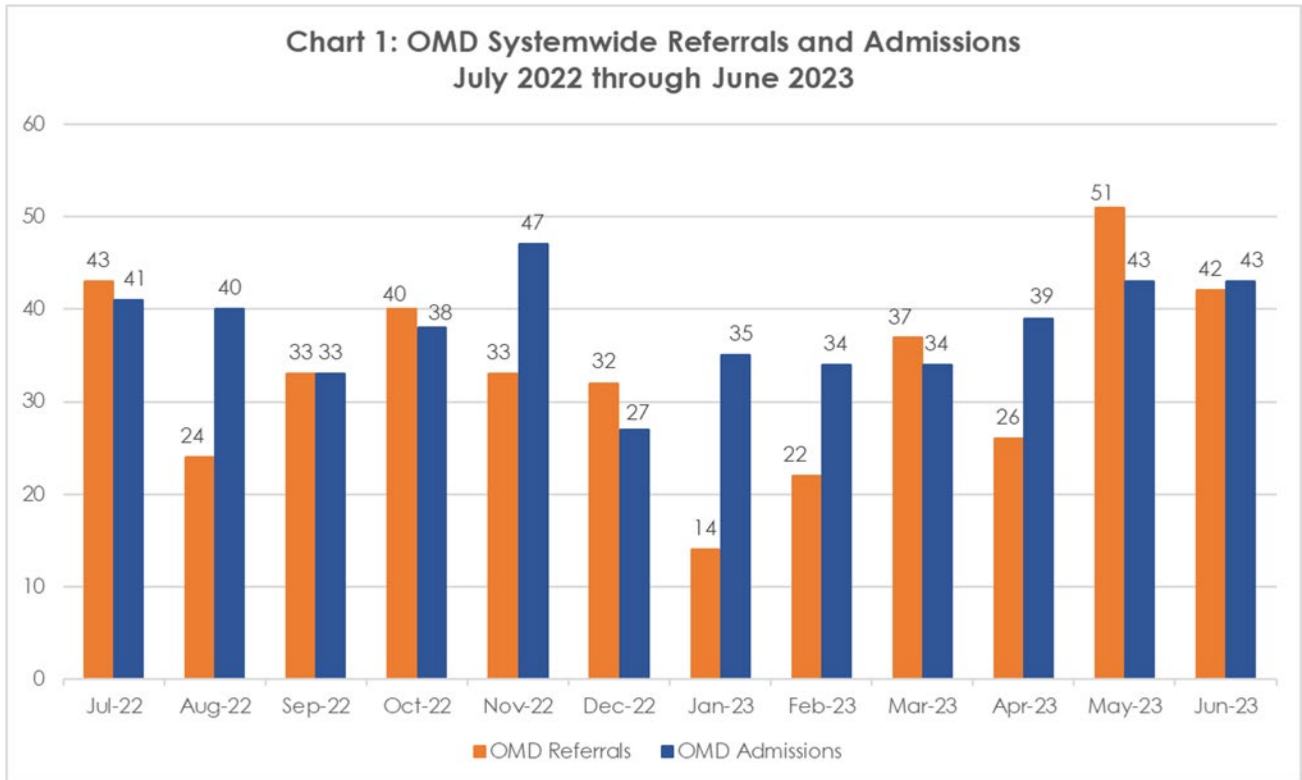
Across inpatient and outpatient programs, DSH treated 1,596 patients committed as OMD in fiscal year (FY) 2022-23. The table below summarizes key statistics across the OMD population.

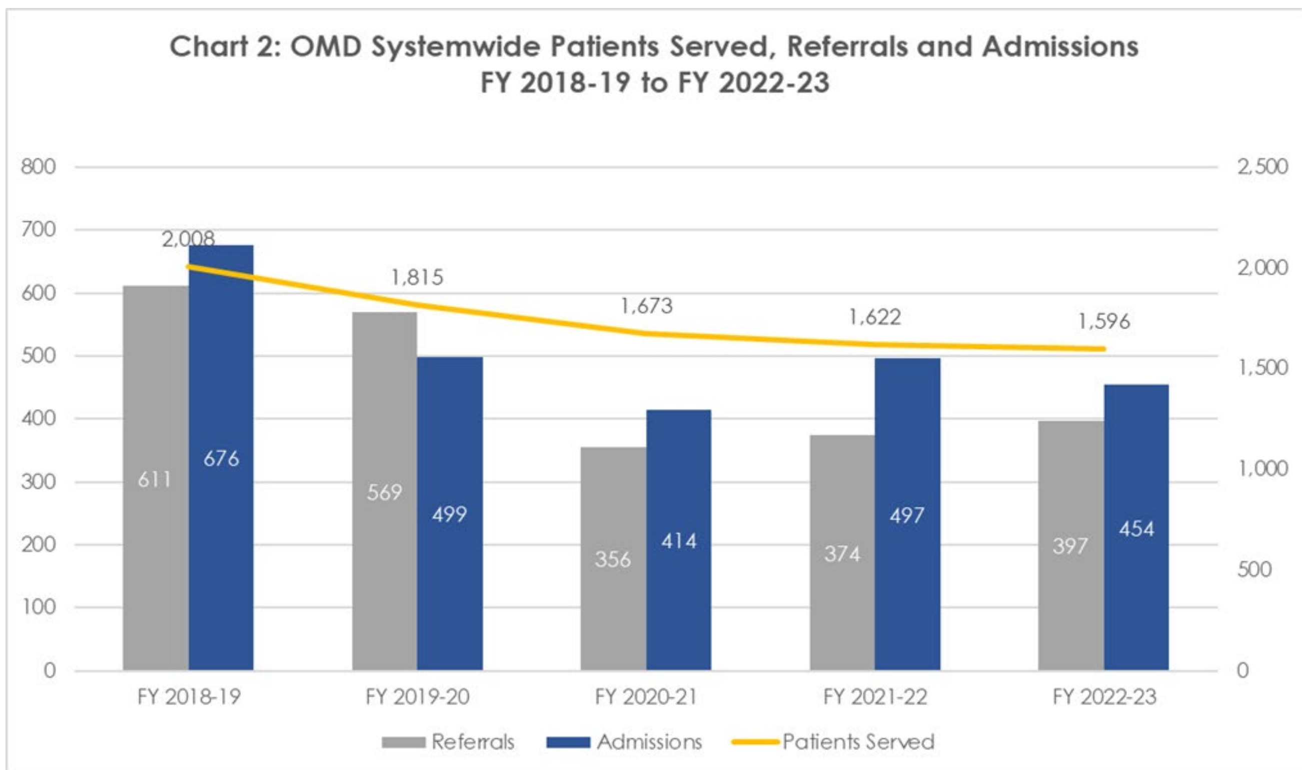
Table 1: System-wide OMD Patient Data Summary[2]

OMD Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	374	397	6%
Patient Admissions	497	454	-9%
Patients Served	1,622	1,596	-2%
Average Daily Census	1,269	1,224	-4%

Chart 1 displays OMD system-wide referrals and admissions by month for FY 2022-23, and Chart 2 displays a five-year period of referrals and admissions for a broader historical view[3].

[2] Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.
[3] Outpatient data is only included in FY 2021-22 and FY 2022-23 (Chart 2).





DSH is statutorily required to admit OMD patients upon completion of their prison sentence since these individuals are not able to safely serve their parole in the community until their severe mental health disorder is in remission and can be kept

in remission. To ensure continuity of care and public safety individuals are discharged from prison directly to a state hospital.

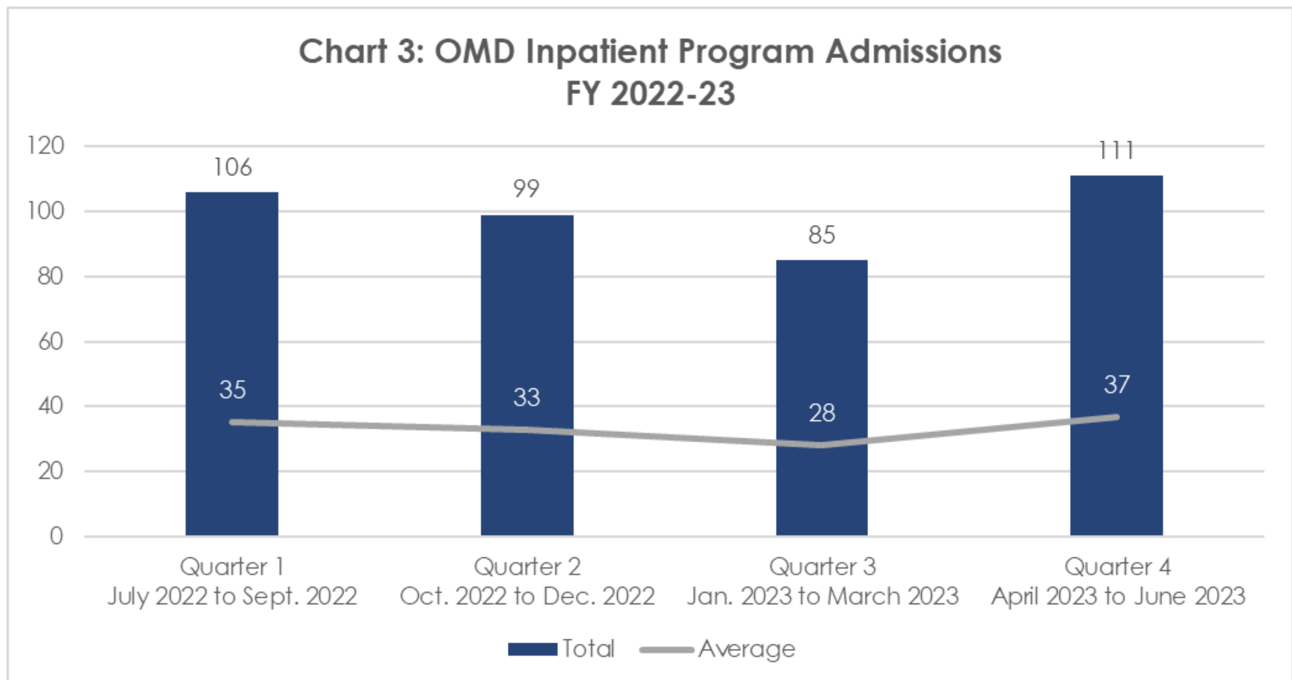
Inpatient Program Metrics

Patients committed to DSH as OMD can receive inpatient treatment within DSH's five state hospitals, with PC 2962 commitment treatment only at DSH-Atascadero (male patients) and DSH-Patton (female patients). Patients who are committed pursuant to PC 2972 may receive treatment across all five state hospitals. In FY 2022-23, the state hospitals treated an average of 1,051 OMD patients daily, with an average census of 1,058 in July 2022 and 1,043 in June 2023.

Table 2: OMD Inpatient Data Summary[4]

OMD Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	421	401	-5%
Patients Served	1,478	1,432	-3%
Average Daily Census	1,112	1,051	-5%

DSH inpatient programs admitted 401 OMD patients in FY 2022-23 with an average of 33 admissions per month. Chart 3 displays Inpatient Program OMD admissions by quarter and the average monthly admissions rate.



[4] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Table 3 displays the number of OMD patients treated in inpatient programs within each FY for the past five years.

Table 3: OMD Patients Served – Inpatient Programs[5]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	2,008	1,815	1,673	1,478	1,430

PC 2962 Inpatient Data

Patients committed as PC 2962 make up 50 percent of the OMD patients treated within inpatient programs.

Table 4: PC 2962 Inpatient Data Summary[6]

PC 2962 Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	337	348	3%
Patients Served	724	719	-1%
Average Daily Census	406	350	-14%

DSH discharged 318 PC 2962 patients from inpatient programs with an average length of stay of 329.9 days, and a median length of stay of 150.5 days. Sixty-seven percent of PC 2962 patients discharged within one year, 86 percent of OMD patients discharged within two years, and only 14 percent had a length of stay longer than two years. The table below depicts the distribution of PC 2962 patients discharged from inpatient treatment in FY 2022-23 by length of stay.

Table 5: PC 2962 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	67%
366 - 1,460 Days (2 - 4 years)	32.7%
1,461 - 1,825 days (4 - 5 years)	0.3%
1,826 - 3,650 days (5 - 10 years)	0%
3,651+ days (10+ years)	0%

Table 6, on the following page, displays inpatient programs length of stay for PC 2962 patients by quarter for FY 2022-23.

[5] Patients served excludes other inpatient and outpatient program transfers.
[6] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Table 6: PC 2962 Inpatient Length of Stay by Quarter – FY 2022-23

PC 2962 Inpatient Programs: Length of Stay	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
Average Length of Stay	358.7	289.4	301.9	370.7	329.9
Median Length of Stay	161.0	136.0	143.0	261.0	150.5
Discharged Count	89	82	76	71	318

For PC 2962 patients yet to discharge the average days in treatment is 310.2 and median days in treatment is 225.

PC 2962 patients can be discharged to a variety of locations including outpatient treatment programs. The table below displays the discharge locations for the 318 patients discharged in FY 2022-23.

Table 7: PC 2962 Inpatient Discharges by Location

PC 2962 OMD Inpatient Discharge Location	Total FY 2022-23	Percent to Total
Community Outpatient Treatment	<11	***%
Discharged to Community	50	16%
Discharged to Parole	232	73%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	25	8%
Locked Medical Facility	<11	***%
Total Discharges	**318**	**100%**

PC 2972 Inpatient Data

Patients committed as PC 2972 make up 50 percent of the OMD patients treated within inpatient programs.

Table 8: PC 2972 Inpatient Data Summary[7]

PC 2972 Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	84	53	-37%
Patients Served	754	713	-5%
Average Daily Census	705	701	-1%

DSH discharged 102 PC 2972 patients from inpatient programs with an average length of stay of 1,397 days (3.8 years), and a median length of stay of 730 days (2.0

[7] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

years). A little over thirty-five percent of PC 2972 patients discharged within one year, 65.7 percent of PC 2972 patients discharged within four years, and 34.3 percent had a length of stay longer than four years. The table below depicts the distribution of PC 2972 patients discharged from inpatient treatment in FY 2022-23 by length of stay.

Table 9: PC 2972 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	35.3%
366 - 1,460 Days (2 - 4 years)	30.4%
1,461 - 1,825 days (4 - 5 years)	4.9%
1,826 - 3,650 days (5 - 10 years)	19.6%
3,651+ days (10+ years)	9.8%

Table 10 displays inpatient programs length of stay by quarter for FY 2022-23.

Table 10: PC 2972 Inpatient Length of Stay by Quarter – FY 2022-23

PC 2972 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	1,525.2 (4.2 yrs.)	1,698.8 (4.7 yrs.)	1,402.2 (3.8 yrs.)	1,071.1 (2.9 yrs.)	1,397.0 (3.8 yrs.)
Median Length of Stay	757.0 (2.1 yrs.)	1,491.5 (4.1 yrs.)	608.0 (1.7 yrs.)	652.0 (1.8 yrs.)	730.0 (2.0 yrs.)
Discharged Count	17	28	24	33	102

For PC 2972 patients yet to discharge the average days in treatment is 2,579.6 (7.1 years) and median days in treatment is 1,982 (5.4 years).

PC 2972 patients can be discharged to a variety of locations including outpatient treatment programs. Table 11 displays the discharge locations for the 102 patients discharged in FY 2022-23.

Table 11: PC 2972 Inpatient Discharges by Location

PC 2972 OMD Inpatient Discharge Location	**Total** FY 2022-23	**Percent to Total**
Community Outpatient Treatment	32	31%
Deceased	<11	***%
Discharged to Community	36	35%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	***	***%
Other/Unknown	<11	***%
Total Discharges	**102**	**100%**

Outpatient Program Metrics

CONREP is the DSH outpatient treatment program for patients committed as OMD. Both PC 2962 and PC 2972 OMD patients can be committed to CONREP. During FY 2022-23, DSH CONREP treated on average 173 OMD patients daily, with an average census of 178 in July 2022 and an ending average census of 162 patients in June 2023.

Table 12: OMD Outpatient Data Summary[8]

OMD Outpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	76	53	-30%
Patients Served	144	164	14%
Average Daily Census	158	173	9%

DSH outpatient programs admitted 53 OMD patients in FY 2022-23 with an average of four admissions per month. Chart 4 displays outpatient program OMD admissions by quarter.

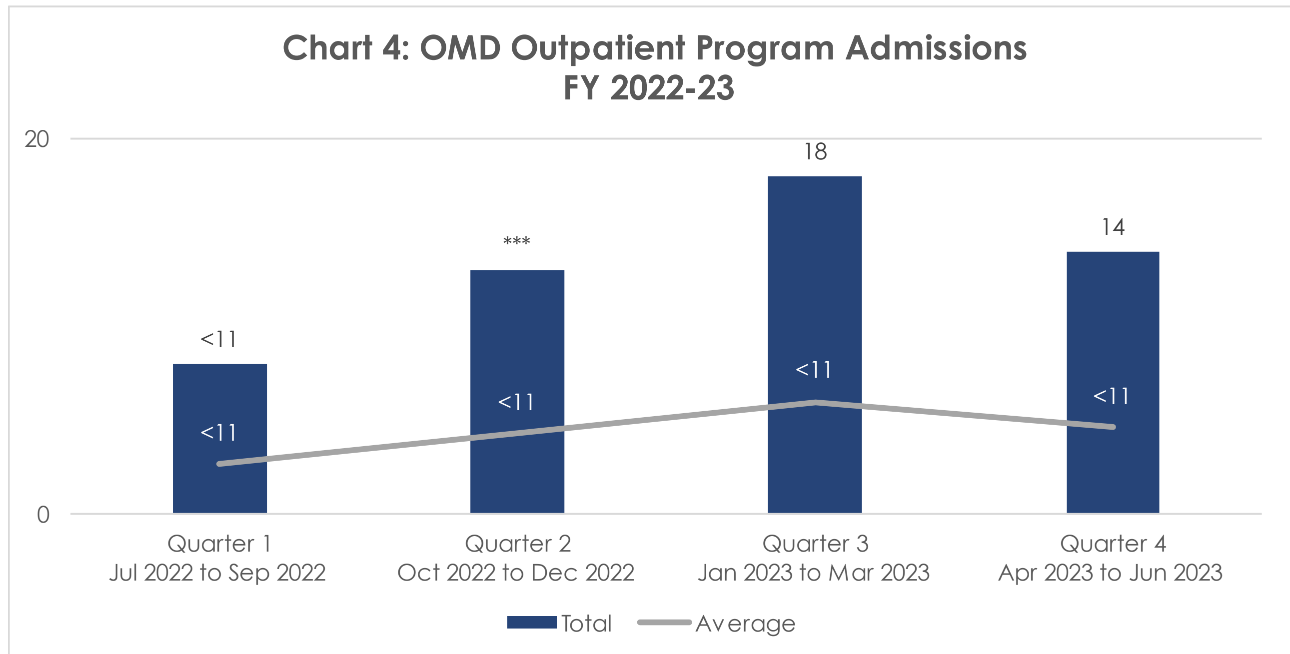


Table 13, below, displays the number of OMD patients treated in outpatient programs within each FY for the past two years.

[8] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Table 13: OMD Patients Served – Outpatient Programs[9]

Patients Treated/Served	FY 2021-22	FY 2022-23
	144	164

DSH discharged 65 OMD patients from outpatient programs with an average length of stay of 840.2 days (3.2 years) and a median length of stay of 333 days (0.91 years) across all outpatient programs. Fifty-five percent of OMD patients discharged within one year, 86 percent of OMD patients discharged within four years, and only 14 percent had a length of stay longer than four years. The table below depicts the distribution of OMD patients discharged from outpatient treatment in FY 2022-23 by length of stay.

Table 14: OMD Outpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	55%
366 - 1,460 Days (2 - 4 years)	31%
1,461 - 1,825 days (4 - 5 years)	2%
1,826 - 3,650 days (5 - 10 years)	8%
3,651+ days (10+ years)	5%

Table 15 displays outpatient length of stay by quarter for FY 2022-23.

Table 15: OMD Outpatient Length of Stay by Quarter – FY 2022-23

OMD Outpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	1,075.5 (2.9 yrs.)	1,455.7 (4.0 yrs.)	568.5 (1.6 yrs.)	697.2 (1.9 yrs.)	840.2 (2.3 yrs.)
Median Length of Stay	175.5 (0.5 yrs.)	507.5 (1.4 yrs.)	350.5 (0.96 yrs.)	314.0 (0.86 yrs.)	333.0 (0.91 yrs.)
Discharged Count	***	<11	22	21	65

[9] Patients served excludes other inpatient and outpatient program transfers.

POPULATION PROFILE
Sexually Violent Predator Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits Sexually Violent Predator (SVP) patients under Welfare and Institutions Codes (WIC) 6602 and 6604: Sexually Violent Predator. SVP commitments are civil commitments of individuals released from prison who meet criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses against one or more victims, and who have a diagnosed mental disorder that makes the person a danger to the health and safety of others in that it is likely that they will engage in sexually violent criminal behavior.

Potential SVP patients/inmates are screened by CDCR and Board of Parole Hearings (BPH) and referred to DSH for full evaluation to determine whether the individuals meet the criteria of an SVP before the completion of their prison term. DSH refers the SVP petition to the county of commitment no less than 20 days prior to the prisoner's release date. If or when the District Attorney (DA) files an SVP petition, the patient/inmate is transferred to county jail pending the WIC section 6602 probable cause hearing. DSH admits patients committed as SVP once there is a WIC section 6602 finding of probable cause. After a WIC 6602 probable cause finding, then a commitment trial is held and, if adjudged to be an SVP under WIC section 6604, the individual is committed to a state hospital for an indeterminate period of time. SVP patients can petition for release, be recommended for outpatient status by DSH, or be found to no longer meet the SVP criteria by DSH.

Legal Statutes and Commitments

- WIC 6602 – Sexually Violent Predator Probable Cause
- WIC 6604 – Sexually Violent Predator
- WIC 6601.3 – Sexually Violent Predator BPH Hold
- WIC 6600 – Sexually Violent Predator Court Hold
- PC 1610 – Temporary admission while waiting for court revocation of outpatient status

Requirements for Discharge

Once a court determines an individual meets the criteria for an SVP commitment, the individual is admitted to a DSH hospital. These patients undergo an annual review process where the patient's SVP status is evaluated by a DSH forensic evaluator, and an update is provided to the court. If DSH provides the court with the opinion that the individual no longer meets SVP criteria, or that the individual can be treated in a less restrictive setting, DSH will then authorize the patient to petition the court for release, and a court hearing is then held to consider the petition. The hearing set as

a result of the patient's petition is to determine whether the status of their mental disorder in that they can be safely treated in the community while under supervision and treatment and should be released from the hospital under conditional release to the community; or whether their condition has so changed that they no longer meet the criteria to be designated an SVP and should be unconditionally released from their SVP commitment to DSH.

If the court agrees that the patient will not pose a public safety threat if conditionally released into a supervised program, it will order the patient be conditionally released. If the patient is conditionally released, DSH's Forensic Conditional Release Program (CONREP) provides treatment, monitoring and supervision of the patient while they are in the community. Alternatively, the court may decide that the patient no longer meets the statutory criteria to be designated as an SVP and order their unconditional release from DSH. If a patient is unconditionally released, a CDCR parole agent takes over the monitoring and supervision of that individual in the community while they are on parole.

DSH Treatment Continuum & Services

Patients committed as SVP have been determined to have committed a sexually violent offense that involve predatory elements, and many have mental disorders that are not amenable to standard medication treatments, as such, treatment for SVP patients typically requires long-term treatment. Psychosocial treatments, relapse prevention/wellness, and recovery action planning are emphasized and reinforced across all clinical disciplines and treatment modalities. To assess dangerousness and develop effective treatments to reduce violence risk, specialized violence risk assessments must be conducted to both guide treatment and measure progress in treatment.

DSH must submit an annual report to the court of the SVP patient's mental condition, including a review of whether they still meet the SVP criteria, whether conditional release to a less restrictive environment or unrestricted discharge would be in the best interest of the individual, and whether conditions could be imposed upon release that would adequately protect the community. Before being recommended for release, the SVP patient must demonstrate long-term stability and adherence to treatment, as well as demonstrate an understanding of their sexual violence risk factors and patterns of thinking that relates to their criminal activity patterns. Furthermore, the SVP patient must be able to demonstrate that they would take preventive actions to avoid or mitigate any factors that would increase their sexual violence risk.

Although SVP patients are admitted to DSH because of mental illness and dangerousness, all patients (including SVP patients) have the right to refuse treatment, unless individually directed by a court to comply. This can effectively

lengthen the patient's stay at the state hospital if a patient chooses not to actively engage or fully participate in the treatments recommended by their treatment team.

Programs

DSH provides sex offense treatment to SVP patients through inpatient care within State Hospitals, at DSH-Coalinga (males) and DSH-Patton (females), and on an outpatient basis in CONREP. In addition to the core sex offense treatment program, other supplemental treatment is offered to meet the individualized needs of patients such as but not limited to substance abuse treatment, life skills and vocational training and anger management. CONREP is considered the final phase of the sex offense treatment program which is about applying all the skills learned while in the hospital to a supervised outpatient setting and ultimately supporting a safe reintegration of the individual back to the community.

DSH Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals.
Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community.

Population Data

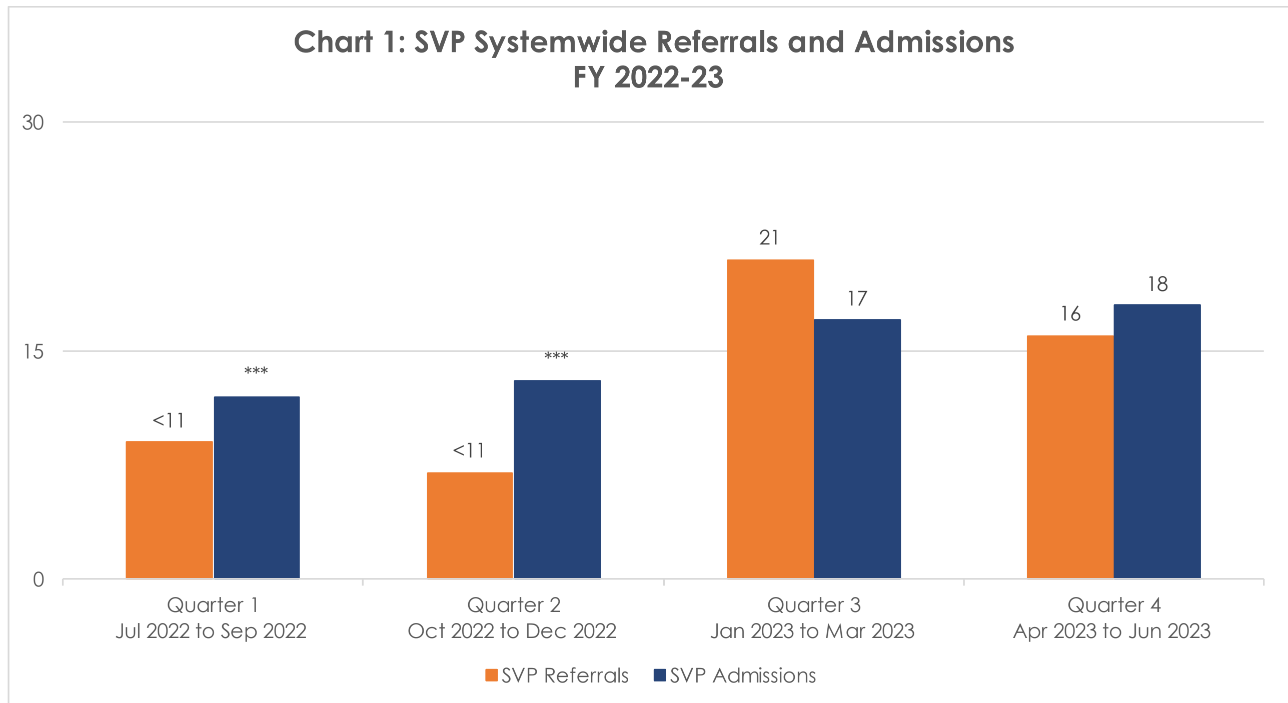
System-wide Metrics

Across inpatient and outpatient programs, DSH treated 1,032 patients designated as SVP, an increase of four percent from prior year. DSH had an average daily census of 977 SVP patients during fiscal year (FY) 2022-23 with no significant change from 976 SVP designated patients in July 2022, to 973 in June 2023. The table below summarizes key statistics across the SVP population.

Table 1: System-wide SVP Patient Data Summary[1]

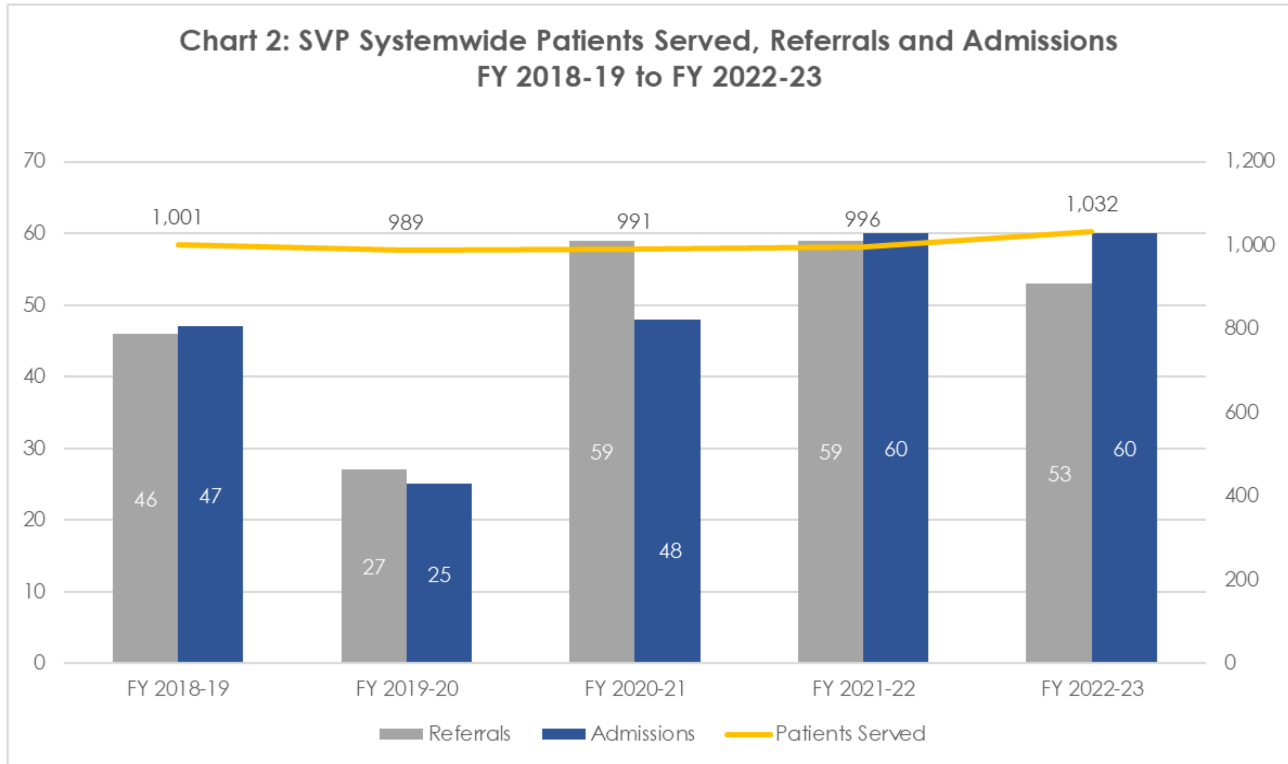
SVP Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	59	53	-10%
Patient Admissions	60	60	0%
Patients Served	996	1,032	4%
Average Daily Census	950	977	3%

Chart 1 displays SVP system-wide referrals and admissions for FY 2022-23.



[1] Referral counts do not reflect referrals for SVP evaluation. Referrals reflect the number of patients committed as SVP once there is a WIC section 6602 finding of probable cause. Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Chart 2 displays a five-year period of referrals and admissions for a broader historic view.[2]



The DSH system-wide SVP Pending Placement List (PPL) decreased 45 percent from the prior FY. FY 2022-23 began with 24 SVP patients pending placement in July 2022 and decreased by 54 percent to 11 patients pending placement in June 2023. The table below identifies the SVP PPL as of June 30th of the corresponding year.

Table 2: System-wide SVP Pending Placement List[3]

SVP Patients Pending Placement	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	<11	<11	11	20	11

Inpatient Program Metrics

Patients committed to DSH as SVP receive inpatient treatment at DSH-Coalinga. During FY 2022-23, DSH-Coalinga treated on average 956 SVP patients daily, maintaining a stable census across the FY. In July 2022, the average census was 957, decreasing slightly to 953 SVP patients in June 2023.

[2] Outpatient data is only included in FY 2021-22 and FY 2022-23 (Chart 2).
[3] The pending placement list reflects patients pending inpatient treatment.

Table 3: SVP Inpatient Data Summary[4]

SVP Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	55	57	4%
Patients Served	981	1,013	3%
Average Daily Census	933	956	2%

DSH inpatient programs admitted 57 SVP patients in FY 2022-23 with an average of five admissions per month. Chart 3 displays inpatient program SVP admissions by quarter and the average monthly admissions rate.

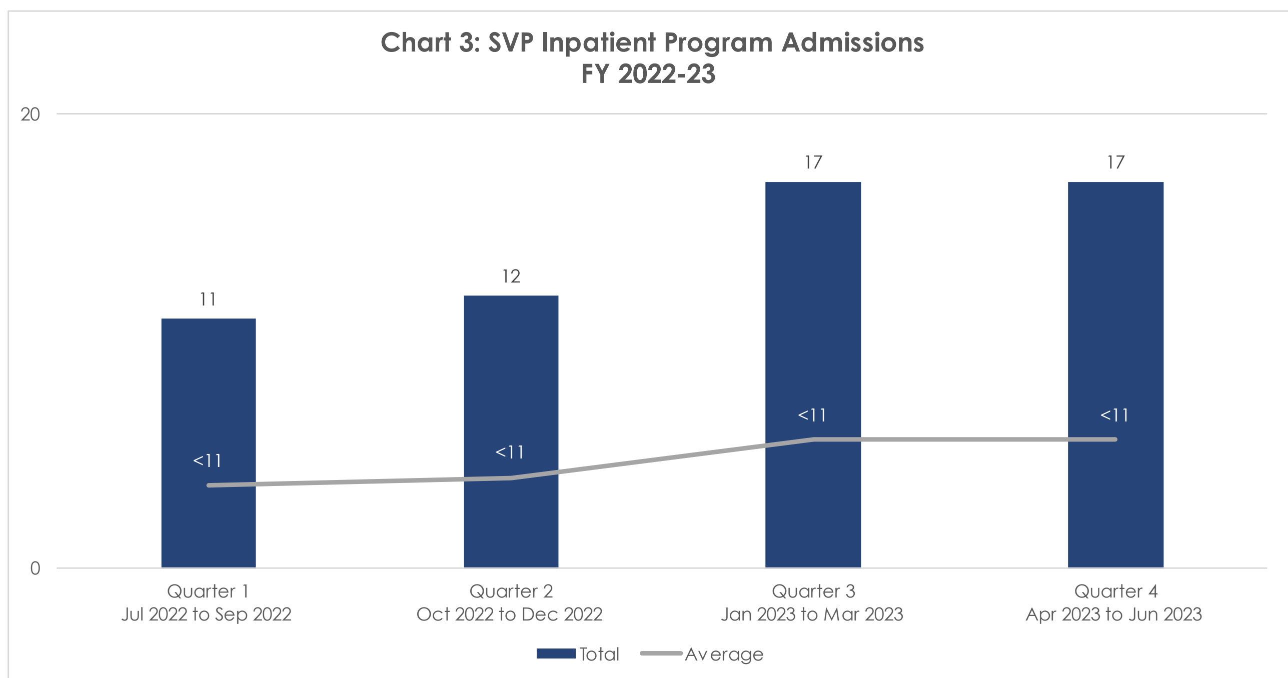


Table 4, below, displays the number of patients treated across the year.

Table 4: SVP Patients Served – Inpatient Programs[5]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	1,001	989	991	981	1,013

[4] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.
[5] Patients served excludes other inpatient and outpatient program transfers.

WIC 6602 Inpatient Data

Patients committed pursuant to WIC 6602 make up 44 percent of the SVP patients treated within inpatient programs.

Table 5: WIC 6602 Inpatient Data Summary[6]

WIC 6602 Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	50	39	-22%
Patients Served	451	449	-0.4%
Average Daily Census	398	400	0.3%

DSH discharged 36 WIC 6602 patients from inpatient programs with an average length of stay of 4,474.7 days (approximately 12 years) and a median length of stay of 4,755 days (approximately 13 years). Zero percent of WIC 6602 patients discharged within the first year of their stay, six percent discharged within the first five years of their stay, 31 percent discharged within ten years of their stay, and 69 percent had a length of stay longer than 10 years. The table below depicts the distribution of WIC 6602 patients discharged from inpatient treatment in FY 2022-23 by length of stay.

Table 6: WIC 6602 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	0%
366 - 1,460 Days (2 - 4 years)	6%
1,461 - 1,825 days (4 - 5 years)	0%
1,826 - 3,650 days (5 - 10 years)	25%
3,651+ days (10+ years)	69%

Table 7, on the following page, displays inpatient programs length of stay for WIC 6602 patients by quarter for FY 2022-23.

[6] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Table 7: WIC 6602 Inpatient Length of Stay by Quarter – FY 2022-23

6602 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	4,967.4 (13.6 yrs.)	4,125.1 (11.3 yrs.)	4,389.9 (12.0 yrs.)	4,774.6 (13.1 yrs.)	4,474.7 (12.3 yrs.)
Median Length of Stay	5,222.0 (14.3 yrs.)	3,711.0 (10.2 yrs.)	4,981.0 (13.6 yrs.)	5,046.5 (13.8 yrs.)	4,755.0 (13.0 yrs.)
Discharged Count	<11	11	12	<11	36

For WIC 6602 patients yet to discharge the average days in treatment is 2,880.3 (7.9 years) and median days in treatment is 2,338.0 (6.4 years).

Table 8 displays the discharge locations for the 36 WIC 6602 patients discharged in FY 2022-23.

Table 8: WIC 6602 Inpatient Discharges by Location

6602 Inpatient Programs: Discharge Location	**Total** FY 2022-23	**Percent to Total**
Deceased	<11	***%
Discharged to Community[7]	30	83%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	<11	***%
Total Discharges	**36**	**100%**

<u>WIC 6604 Inpatient Data</u>

Patients committed pursuant to WIC 6604 make up 56 percent of the SVP patients treated within inpatient programs.

Table 9: WIC 6604 Inpatient Data Summary[8]

WIC 6604 Inpatient Data	**FY 2021-22**	**FY 2022-23**	**Percent Change from Prior FY**
Patient Admissions	<11	18	260%
Patients Served	530	564	6.4%
Average Daily Census	535	557	4.1%

DSH discharged 20 WIC 6604 patients from inpatient programs with an average length of stay of 5,392.2 days (approximately 15 years) and a median length of stay

[7] Less than 11 patients were conditionally discharged, the remaining were unconditional discharges.
[8] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

of 5,724.5 days (approximately 16 years). Zero percent of WIC 6604 patients discharged within the first year of their stay, five percent discharged within the first five years of their stay, 15 percent discharged within ten years of their stay, and 85 percent had a length of stay longer than 10 years. The table below depicts the distribution of WIC 6604 patients discharged from inpatient treatment in FY 2022-23 by length of stay.

Table 10: WIC 6604 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	0%
366 - 1,460 Days (2 - 4 years)	5%
1,461 - 1,825 days (4 - 5 years)	0%
1,826 - 3,650 days (5 - 10 years)	10%
3,651+ days (10+ years)	85%

The table below displays the FY 2022-23 length of stay by quarter for WIC 6604 commitments discharged from inpatient programs in FY 2022-23.

Table 11: WIC 6604 Inpatient Length of Stay by Quarter – FY 2022-23

6604 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	5,157.3 (14.1 yrs.)	5,582.0 (15.3 yrs.)	5,215.0 (14.3 yrs.)	5,439.7 (14.9 yrs.)	5,392.2 (14.8 yrs.)
Median Length of Stay	5,426.0 (14.9 yrs.)	6,030.0 (16.5 yrs.)	5,898.0 (16.2 yrs.)	5,651.0 (15.5 yrs.)	5,724.5 (15.7 yrs.)
Discharged Count	<11	<11	<11	<11	20

For WIC 6604 patients yet to discharge the average days in treatment is 4,663.9 days (12.8 years) and the median days in treatment is 5,327.0 days (14.6 years).

The table below displays the discharge locations for the 20 WIC 6604 patients discharged in FY 2022-23.

Table 12: WIC 6604 Inpatient Discharges by Location

6604 Inpatient Programs: Discharge Location	**Total** FY 2022-23	**Percent to Total**
Community Outpatient Treatment	<11	***%
Deceased	***	***%
Total Discharges	**20**	**100%**

Outpatient Program Metrics

DSH SVP outpatient treatment programs are provided by CONREP. During FY 2022-23, DSH outpatient programs treated on average 21 SVP patients. In July 2022, the SVP patient average census was 19 with a nine percent growth to 21 SVP patients in June 2023.

DSH outpatient programs admitted less than 11 SVP patients in FY 2022-23 with an average of less than one percent admissions per month. Chart 4 displays outpatient program SVP admissions by quarter.

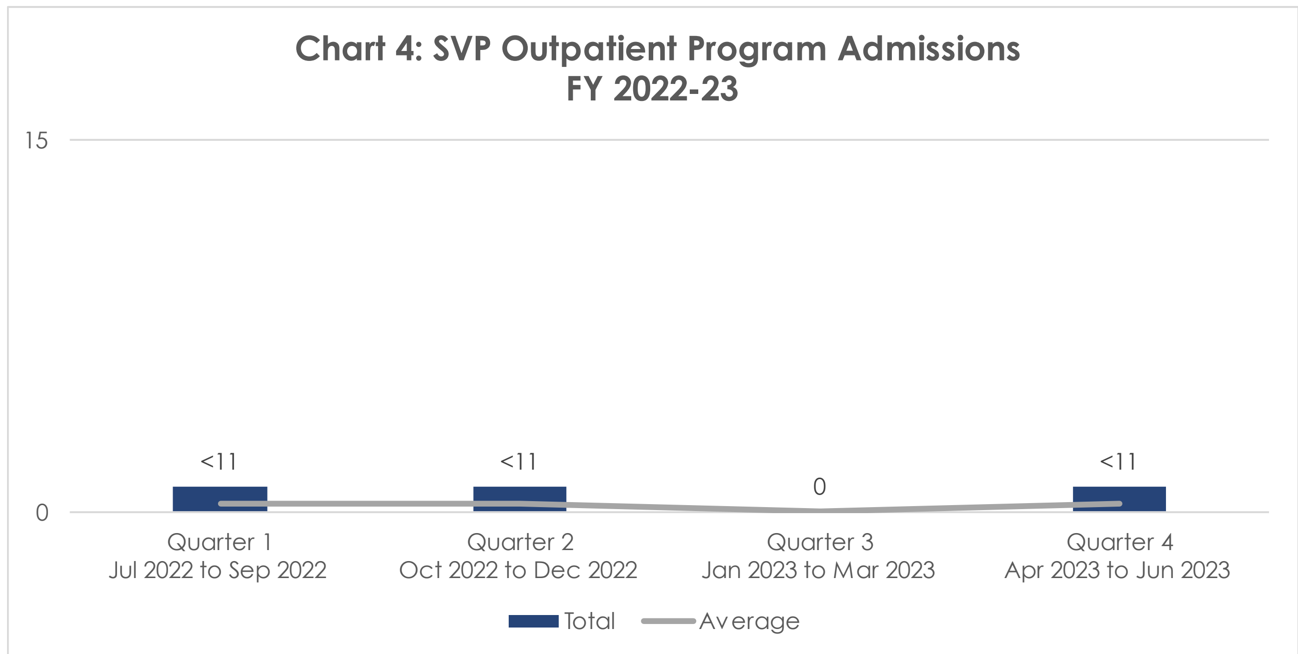


Table 13, below, displays the number of patients treated across the year in outpatient programs.

Table 13: SVP Patients Served – Outpatient Programs[9]

	FY 2021-22	FY 2022-23
Patients Treated/Served	15	19

DSH discharged less than 11 SVP patients from outpatient programs with an average length of stay and a median length of stay of 2,702.0 days (over 7 years) across all programs. Zero percent of SVP patients discharged within the first five years of their stay and 100 percent of the SVP patients discharged within ten years of their stay. Table 14, on the following page, displays outpatient length of stay by quarter.

[9] Patients served excludes other inpatient and outpatient program transfers.

Table 14: SVP Outpatient Length of Stay by Quarter – FY 2022-23

SVP Outpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	0.0	2,231.0 (6.1 yrs.)	0.0	3,173.0 (8.7 yrs.)	2,702.0 (7.4 yrs.)
Median Length of Stay	0.0	2,231.0 (6.1 yrs.)	0.0	3,173.0 (8.7 yrs.)	2,702.0 (7.4 yrs.)
Discharged Count	0	<11	0	<11	<11

DEPARTMENT OF STATE HOSPITALS - ATASCADERO

HISTORY

The Department of State Hospitals (DSH)-Atascadero is a secure forensic hospital located on the Central Coast of California, in San Luis Obispo County. It opened in 1954 and is a psychiatric hospital constructed within a secure perimeter. DSH-Atascadero treats only male patients, the majority of which are remanded for treatment by county superior courts or by the California Department of Corrections and Rehabilitation (CDCR). The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,275 beds. In fiscal year (FY) 2022-23, DSH-Atascadero served 1,067 patients. The commitment categories of patients treated at DSH-Atascadero are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,280 employees work at DSH-Atascadero providing 24/7 care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The residential treatment programs, in conjunction with Recovery and Mall Services (defined below), provide a variety of patient, group, and unit-wide skills training, rehabilitative and enrichment activities. These activities are prescribed by the treatment team according to the patient's identified interests and assessed needs. Included in these activities is a vocational rehabilitation program which provides the patients with the opportunity to learn an increasing number of vocational and work skills under the direction of trained vocational counselors and a variety of school-based classes where patients can improve academic achievement, receive a General Education Diploma, or pursue advanced independent studies.

Program management is responsible for ensuring a safe and therapeutic environment through the appropriate management of resources and the delivery of group psychotherapy, psychoeducational and rehabilitation treatment specific to the patients' needs. When indicated, individual patient psychotherapy, vocational training, and educational training are also provided.

Treatment Plan

Treatment planning is directed toward the goal of helping patients to recover from psychiatric disability, which includes the reduction of symptoms, acquisition of skills for coping with the effects of mental illness, successful fulfillment of constructive adult roles, and the development of supports, which in combination, will permit maximum independence and quality of life. The planning process offers the patient, family members, relatives, significant others, and authorized representatives the full opportunity to participate meaningfully in the recovery and discharge process.

Each patient will have a comprehensive, individualized treatment plan based on the integrated assessments of mental health professionals. Therapeutic and rehabilitation services are designed to address each patient's needs and to assist

the patient in meeting specific treatment goals, consistent with generally accepted professional standards of care. Such plans are developed and reviewed on a regular basis in collaboration with the patient.

Treatment Team

The treatment team consists of an interdisciplinary core of members, including at least the patient, treating psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, and psychiatric technician, and may include the patient's family, guardian, advocates, and attorneys as appropriate. Based on the patient's needs, other members may also include, but are not limited to registered dietitian, pharmacist, teacher, physical therapist, speech-language pathologist, occupational therapist, vocational services staff, and psychiatric nurse practitioner.

Families and officials (i.e., conservators) may be included as active participants with the team and may be of considerable assistance in assessment, planning, treatment, and post-hospital care of the patients. At the time of admission, families shall be notified so that they may meet with the team, provided the patient gives consent for notification.

Provision of Treatment, Rehabilitation, and Supplemental Activities

DSH's goal is to provide individualized active recovery services that focus on maximizing the functioning of persons with psychiatric disabilities. DSH endeavors to identify, support, and build upon each recovering patient's strengths to achieve maximum potential towards his or her hopes, dreams, and life goals.

Recovery and Mall Services (RMS)

RMS is a clinical treatment program that utilizes Recovery oriented Psychosocial Rehabilitation philosophy to provide quality, evidence based, recovery focused, therapeutic and rehabilitation services, as well as supplemental leisure activities designed to facilitate the psychiatric rehabilitation of patients at DSH-Atascadero. All services provided through RMS promote increased wellness and independent functioning. RMS provides centralized campus locations for treatment where facilitators from throughout the hospital may provide approved, scheduled treatment groups. These areas include the Phoenix Campus, Gymnasium, Community Center, Music Center, Main Courtyard and Art Center.

The RMS department offers Interfaith Services, Volunteer Services, Library Services through the Logan Library Patient and Professional Libraries, Aztec Adult School, Graphic Arts Services, Barbershop Services and Substance Use Recovery

Services. In addition, RMS also offers Vocational Training Programs that include Printing/Graphic Arts and Landscape Gardening. Furthermore, RMS offers scheduled hospital-wide supplemental activities, events and meetings including but not limited to: Phoenix Club, Incentive Bingo and Community Center, Evening Open Gym, Monthly Birthday Party, and the Hospital Advisory Council meetings.

Central Medical Services (CMS)

CMS provides medical care and evaluation to all patients in the hospital. These services include radiology, public health, laboratory, physical therapy, dentistry, pharmacy, medical clinics, unit sick call, contractual services inside and outside the hospital, and review of community-based consultations. Services are available to patients on referral from general physicians and psychiatrists who have primary responsibility for the care of patients on residential treatment units.

Enhanced Treatment Program (ETP)

The ETP is designed to provide enhanced treatment in a secure setting for patients at the highest risk of most dangerous behavior. The ETP is intended to provide increased therapy opportunities within a structured, least restrictive environment. The ETP is to be utilized when safe treatment is not possible in a standard treatment environment. The pilot is driven by Assembly Bill 1340. Unit 29 opened in September 2021 and the Budget Act of 2022 postponed the activation of Units 33 and 34 due to the ongoing bed capacity pressures within the DSH system.

The ETP model allows for enhanced staffing which includes a complement of Clinical, Nursing and Hospital Police Officer (HPO) staff. Classifications utilized include Staff Psychiatrist, Clinical Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse, and Psychiatric Technician.

ACCREDITATION AND LICENSURE

DSH-Atascadero is accredited by The Joint Commission (TJC) an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded and whether certain conditions or reporting requirements should be implemented to maintain accreditation status. TJC standards deal with subject matter such as organization quality, patient safety, provision of care, treatment, and services, as well as the environment in which care is provided.

DSH-Atascadero is licensed by the California Department of Public Health and has eight units licensed as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. DSH-Atascadero also has 26 units licensed as Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

TRAINING AND INTERNSHIPS

DSH-Atascadero offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Atascadero's training programs.

DSH-Atascadero Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation • Nursing Students Preceptorship
Pharmacy [1]	• Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Physician and Surgeon [2]	• Accepts Contracted Students
Psychiatric Technicians [3]	• Psychiatric Technician Trainee • Pre-Licensed Psychiatric Technician • 20/20 Psychiatric Technician Training Program
Psychology	• American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	• Accredited Dietetic Internship • Contracted Cal-Poly San Luis Obispo Dietetic Internship
Rehabilitation Therapy	• Recreation Therapy (Student Assistants) • Music Therapy (Student Assistants)
Social Work	• Paid MSW Internship (Graduate Student Assistant) • Social Work Intern (Student Assistant)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[2] **Physician and Surgeon:** Accepts Family Nurse Practitioner students who need clinical hours. They can execute contracts with the school to formalize these rotations.

[3] **Psychiatric Technicians:** 1. Psychiatric Technician Trainees are currently enrolled in a Psychiatric Technician School and work part time inside DSH hospitals (up to 20 hours/week). 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities. 3. 20/20 Psychiatric Technician training programs are open to current employees that have been accepted into a Psychiatric Technician School. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

DEPARTMENT OF STATE HOSPITALS – COALINGA

HISTORY

The Department of State Hospitals (DSH)-Coalinga is located at the edge of the Coastal Mountain Range on the western side of Fresno County. Coalinga is halfway between Los Angeles and San Francisco and 60 miles southwest of Fresno.

DSH-Coalinga opened in 2005 and began treating forensically committed patients, most of which are sexually violent predators (SVPs). It is a self-contained psychiatric hospital constructed with a security perimeter. California Department of Corrections and Rehabilitation (CDCR) provides perimeter security as well as transportation of patients to outside medical services and court proceedings. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,500 beds. In fiscal year (FY) 2022-23, DSH-Coalinga served 1,341patients. The commitment categories of patients treated at DSH-Coalinga are as follows:

Patient Commitments	Code Section
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026
Mentally Disordered Sex Offenders	6316 (WIC)
Sexually Violent Predators	6602/6604

HOSPITAL STAFF

Approximately 2,490 employees work at DSH-Coalinga providing 24/7 care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition,

there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The fundamental goal of the DSH-Coalinga Sex Offenders Treatment Program is for the patient to acquire pro-social skills and to prevent recurrence of sexual offending. The program combines components of the Self-Regulation/Better Life models with the principles of Risk-Need-Responsivity (RNR). This combined approach strengthens the patient's self-regulation skills to prepare for a life free of sexual offending. The three principals of the RNR model are explained here in more detail.

The risk principle involves matching the intensity of treatment to the patient's risk level of reoffending, with high-risk offenders receiving more intensive and extensive treatment than low-risk offenders. Offense risk is determined by the combination of static and dynamic risk factors.

The need principle focuses on assessing dynamic risk factors and targeting them in treatment. Dynamic Risk Factors are defined as enduring but changeable features of an offender; they are amenable to interventions, and when successfully addressed, result in a decrease in recidivism risk.

The responsivity principle states that services should be delivered in a manner that is engaging and consistent with the learning style of the individual. Examples include fostering strengths; establishing meaningful relationships; and attending to relevant characteristics such as age, cognitive skills, cultural factors, and emotional regulation issues. It also states that the primary treatment components should use social learning and cognitive-behavioral approaches. Empirical studies indicate that adhering to RNR principles can maximize treatment effects and reduce recidivism.

The Self-Regulation/Better Life model also provides some educational opportunities, vocational services, and recreational activities. Individuals with intellectual disabilities or severe psychiatric disorders participate in programs adapted for their treatment needs.

LICENSURE

DSH-Coalinga is licensed by the California Department of Public Health. DSH-Coalinga has two units designated as acute psychiatric. An acute psychiatric

facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. In addition, DSH-Coalinga currently has 24 units licensed as an Intermediate Care Facility (ICF). An ICF is defined as a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care. In May of 2023, DSH-Coalinga converted an additional Residential Recovery Units (RRU) to an ICF, bringing the total number of licensed units to 24. In addition, DSH-Coalinga has six unlicensed RRU's, which provides inpatient care to patients who are required to reside at DSH but have a lesser need for supervision.

TRAINING AND INTERNSHIPS

DSH-Coalinga offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Coalinga's training programs.

DSH-Coalinga Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation • Nursing Students Preceptorship
Pharmacy [1]	• Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Psychiatric Technicians [2]	• Psychiatric Technician Trainee • Pre-Licensed Psychiatric Technicians • 20/20 Psychiatric Technician Training Program
Psychology	• American Psychological Association Approved Pre-Doctoral Internship
Rehabilitation Therapy [3]	• Recreation Therapy (Student Assistants) • Recreation Therapy Internship Program • Music Therapy (coming soon)
Social Work [4]	• Masters of Social Work Internships (Graduate Student Assistants)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[2] **Psychiatric Technicians:** 1. Psychiatric Technician Trainees are currently enrolled in a Psychiatric Technician School and work part time inside DSH hospitals (up to 20 hours/week). 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities. 3. 20/20 Psychiatric Technician training programs are open to current employees that have been accepted into a Psychiatric Technician School. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

[3] **Recreational Therapy Internship:** Recreational Therapy Internship Candidates are in their final semester of their degree and are required to complete a minimum of a 14-week 560-hour internship. Partners can be made with any accredited school in the country with a Recreational

Therapy or Therapeutic Recreation program. The specific DSH-C Recreation Therapy Internship Program lasts for a minimum of 17-weeks due to New Employee Orientation. Once completed, students are eligible for national certification with National Council for Therapeutic Recreation Certification (NCTRC). To ensure the safety and well-being of students, patients, and staff, the internship is designed to follow the guidelines outlined in the American Therapeutic Recreation Association (ATRA) Code of Ethics. DSH-Coalinga can provide current opportunities for skill growth and professional development in accordance with American Music Therapy Association (AMATA) guidelines.

[4] **Social Work:** The Master of Social Work Internship program accepts six Graduate Student Assistants per academic program year. Graduate students are currently enrolled in a Master of Social Work program at an accredited university and complete at least 20 internship hours at DSH-C each week. The Field Instructor and Preceptor for each student will communicate with one another throughout the internship to assess progress and determine appropriate rotation throughout the hospital. The Social Work Department is currently contracted with nine Master of Social Work universities. The contracted schools include University of California (USC), California State University Fresno (CSUF), California State University Bakersfield (CSUB), California State University Monterey Bay (CSUMB), San Jose State University (SJSU), Arizona State University (ASU), Campbellsville University (CU), UMASS Global, and Simmons University.

DEPARTMENT OF STATE HOSPITALS – METROPOLITAN

HISTORY

The Department of State Hospitals (DSH)-Metropolitan opened in 1916 as a self-sufficient facility with its own dairy cows, pigs, chickens, and farmland. Located in Norwalk in Los Angeles (LA) County, today it serves as a modern-day psychiatric facility providing state of the art psychiatric care. The hospital is an open style campus within a security perimeter. Due to concerns raised by the community, DSH-Metropolitan maintains a formal agreement with the City of Norwalk and the LA County Sheriff not to accept patients charged with murder or a sex crime, or at high risk for escape. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,106 beds. In fiscal year (FY) 2022-23, DSH-Metropolitan served 762 patients. The commitment categories of patients treated at DSH-Metropolitan are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,270 employees work at DSH-Metropolitan providing 24/7 care, including psychiatrists, psychologists, social workers, rehabilitation therapists, registered nurses, psychiatric technicians, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, teachers, and other administrative staff.

TREATMENT AND PROGRAMS

DSH-Metropolitan is the first state hospital to have a specialized unit dedicated to Dialectical Behavior Therapy (DBT). DBT is a systematic cognitive-behavioral approach founded in the late 1970s by psychologist Marsha Linehan. It balances principles of acceptance (mindfulness) and change (behaviorism) and is effective for treating complex, difficult-to-treat mental disorders. Research indicates DBT to be effective in reducing:

- Suicidal and self-injurious behaviors
- Treatment resistant depression
- Intense anger or difficulty with controlling emotions
- Impulsive behaviors that are potentially self-damaging (e.g., substance abuse, eating disorders)
- Treatment dropout
- Psychiatric hospitalizations

DSH-Metropolitan has a specialized unit dedicated to DBT as a treatment modality for patients who are diagnosed with a serious mental illness and who typically have a complex response to trauma that directly influenced their attachment styles, coping mechanisms, and interpersonal relationships. Each patient in the DBT Program participates in the following activities:

- DBT Skills Groups which include four modules: Mindfulness, Emotional Regulation, Distress Tolerance, and Interpersonal Relationships
- Homework and Review Group
- Weekly Individual Therapy
- Bi-Weekly Outings
- Groups focused on practicing and applying skills

Other treatment programs include:

Trial Competency Program

The Trial Competency Program is for patients admitted to the hospital pursuant to Penal Code (PC) 1370, Incompetent to Stand Trial (IST). The IST patients are trial defendants determined by the court to be unable to participate in their trial because they are not able to understand the nature of the criminal proceedings or assist counsel in the conduct of their defense due to psychiatric symptoms associated with a mental illness. These patients receive a specialized program of treatment which is specifically designed to help the patient gain the knowledge and skills necessary to return to court. The goal is for the patient to understand court proceedings and effectively participate in their defense. Treating the defendant as IST and returning to court for trial is sometimes followed by a court determination that the defendant is Not Guilty by Reason of Insanity (NGI) and requires further treatment under PC 1026.

Offender with a Mental Health Disorder (OMD) Program

The OMD Program is for patients paroled to the hospital by authority of the Board of Paroles under provisions of PC 2962. Patients may be released to parole, placed in a Conditional Release Program (CONREP), or become civilly committed.

Lanterman-Petris-Short (LPS) Program

The LPS Program provides treatment for civilly committed patients who suffer from severe symptoms of mental illness, who engage in the behaviors that are dangerous to themselves or others, or who are gravely disabled by their mental illness and thereby unable to formulate a viable plan for self-care. The program provides a highly structured treatment environment for re-socialization in preparation for community placement.

Skilled Nursing Facility (SNF)

The fully licensed SNF provides continuous nursing treatment and care for both Penal Code (PC) and civilly committed patients whose primary need is availability of skilled nursing care on an extended basis. Program objectives include the provision of interventions that are person-appropriate, foster hope and caring, and honor the resident's individual rights, cultural differences, spirituality and dignity.

ACCREDITATION AND LICENSURE

DSH-Metropolitan is accredited by The Joint Commission (TJC) an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded and under what conditions that happens. TJC standards evaluate organization quality, safety of care issues and the safety of the environment in which care is provided.

DSH-Metropolitan is licensed by the California Department of Public Health and has 23 units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Metropolitan also has three units designated as a Skilled Nursing Facility (SNF). A SNF means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

TRAINING AND PARTNERSHIPS

DSH-Metropolitan offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of those training programs.

DSH-Metropolitan Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing [1]	• Registered Nursing Clinical Rotation Programs • Nursing Students Preceptorship
Pharmacy [2]	• Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Physician and Surgeon	• Student Volunteer Opportunities
Psychiatric Technicians [3]	• 20/20 Psychiatric Technician Training Programs
Psychiatry	• Pacific Northwest University – Psychiatry Clerkship • Western University of Health Sciences – Psychiatry Clerkship • Psychiatric Fellowship Program for Child Psychiatry
Psychology	• Association of Psychology Postdoctoral and Internship Center – Affiliated Internship Program
Registered Dietitians	• Accredited Dietetic Internship
Rehabilitation Therapy	• Art Therapy (Loyola Marymount University/ Practicum Students) • Music Therapy (American Music Therapy Association National Roster Internship Program /Volunteer Positions) • Recreation Therapy (Volunteer Positions)
Social Work	• Masters of Social Work Internships (Volunteer Positions)

[1] **Nursing:** Preceptorship for Bachelor of Science in Nursing (BSN) and Master of Science in Nursing (MSN) programs available on an individual basis.

[2] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[3] **Psychiatric Technicians:** DSH-Metropolitan offers 20/20 Psychiatric Technician training program for only Psychiatric Technician Assistants to become a Psychiatric Technician. The modified work

hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

DEPARTMENT OF STATE HOSPITALS – NAPA

HISTORY

In 1872, a site was selected, and work began for the erection of the 500-bed, four-story, Gothic Style Hospital building. The Hospital originated in response to overcrowding at Stockton Asylum, the first State Hospital. The Department of State Hospitals (DSH)-Napa opened on Monday, November 15, 1875, and is the oldest State Hospital still in operation. DSH-Napa was once self-sufficient, with its own dairy and poultry ranches, vegetable gardens, orchards, and other farming operations. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,418 beds, but current maximum capacity is 1,374 beds. In fiscal year (FY) 2022-23, DSH-Napa served 1,103 patients. The commitment categories of patients treated at DSH-Napa are as follows:

Patient Commitments	Code Section
Incompetent to Stand Trial	1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026
Recommitment After Expiration of Prison Term (Must have concurrent W&I commitment)	2974
Department of Juvenile Justice	-

HOSPITAL STAFF

Approximately 2,670 employees work at DSH-Napa, providing 24/7 care, including psychologists, psychiatrists, physicians, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT PROGRAMS

Patients are screened prior to being scheduled for admission to ensure that DSH-Napa is the appropriate treatment setting. One treatment program is located outside the Secure Treatment Area (STA) for primarily civil commitments and four programs are located inside the STA for forensic commitments. Within these treatment programs there are residential units, each having a focus on a particular population and treatment. Staff orients the patient to the unit on arrival. Members of the Treatment Team meet with patients and continue the assessment process and develop treatment plans. Once developed, the plan is reviewed regularly by the Treatment Team and updated as the patient progresses, and treatment objectives change. Family, significant others, conservators, Conditional Release Program (CONREP) and the courts may play a role as the patient moves through the continuum of care from admission to discharge.

In addition to the living units there are other service sites. For instance, Mall Services provides a variety of off unit services for patients. Mall Services is a centralized approach to delivering services where the patients and staff from throughout the hospital come together to participate in services. Mall Services represents more of a centralized system of programming rather than a reference to a specific building or certain location. The services are provided, as much as possible, in the context of real-life functioning and in the rhythm of life of the patient. Thus, Mall Services extends beyond the context of a "building or place," and its services are based on the needs of the patient, not the needs of the program, the staff members, or the institution. Vocational Services provides opportunities for patients to develop job skills and habits, as well as earn funds. Educational Services enables patients to continue their education, high school, or college, and provide skills groups for anger management and development of interpersonal skills. Rehabilitation Therapy Services, facilitated by music, dance, art, occupational and recreation therapists, provide treatment groups to engage the patient in wellness and improved quality of life. Rehabilitation Therapy Services also provides physical, occupational, and speech therapies.

Department of Medicine and Ancillary Services provides clinics that deliver various medical services, including, but not limited to primary care, dental, podiatry, neurology, cardiac and obstetrics and gynecology clinics.

The goal of treatment services is to assist patients to recognize and manage psychiatric symptoms. Patients also work on developing socially responsible behaviors, independent living skills, and coping skills to address their mental illness and forensic issues.

Specialty units include:

- Admission units- focused on completion of initial assessments and initiation of behavioral stabilization.
- Incompetent to Stand Trial (Penal Code (PC) 1370) treatment, focuses on trial competency treatment, attainment of competency and return them to court for adjudication of pending charges. Patients participate in a wide range of mental health groups and therapeutic activities to assist in addressing symptoms and behaviors that may interfere with their ability to understand the court proceedings and to cooperate with their attorney in preparing a defense.
- Other commitments proceed from admission units through the continuum of care from stabilization to discharge. During a patient’s stay some patients may receive specialized treatment.
    - Dialectic Behavior Therapy (DBT) involves individualized treatment and unit milieu management that focuses on supporting patient's use of DBT skills to minimize harm to self and others
    - Treatment for polydipsia (intoxication resulting from excessive consumption of fluids)
    - Sex offender treatment
    - Intensive Substance Abuse Recovery
    - Geropsychiatric
- Discharge units focus on skills development for community living and on relapse prevention. Each patient prepares a personalized relapse prevention plan. The Treatment Teams work closely with CONREP towards returning patients to the community under CONREP supervision.

ACCREDITATION AND LICENSURE

DSH-Napa is accredited by The Joint Commission (TJC) and independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The

survey results are used to determine whether accreditation should be awarded and whether certain conditions or reporting requirements should be implemented to maintain accreditation status. TJC standards deal with subject matter such as organization quality, patient safety, provision of care, treatment, and services, as well as the environment in which care is provided.

DSH-Napa is licensed by the California Department of Public Health and has two units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. DSH-Napa has one unit designated as a Skilled Nursing Facility (SNF). A SNF is a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. Additionally, DSH-Napa has 33 units designated as an Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

TRAINING AND PARTNERSHIPS

DSH-Napa offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Napa's training programs.

DSH-Napa Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation
Pharmacy [1]	• Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Psychiatric Technicians [2]	• Psychiatric Technician Apprentice • Pre-Licensed Psychiatric Technicians • Psychiatric Technician Prorams Clinical Rotation
Psychiatry	• UC Davis, Psychiatry and Law • Touro University • Clinical Clerkships for Medical School Graduates • Residency Program with St. Joseph Medical Center
Psychology	• American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	• Accredited Dietetic Internship
Rehabilitation Therapy	• Recreation Therapy Internship • Occupational Therapy • Music Therapy • Dance Movement Therapy • Art Therapy
Social Work	• Masters of Social Work Internships (Open to 2nd year MSW students)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University. University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California Health Sciences

University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[2] **Psychiatric Technicians:** 1. Psychiatric Technician Apprentice - This class is limited term and designed for entrance and performance in an apprentice program leading to status as a licensed Psychiatric Technician. Persons in this class receive training under the provisions of apprenticeship standards and written apprentice agreements under Chapter 4, Division 3, California Labor Code. 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities.

DEPARTMENT OF STATE HOSPITALS – PATTON

HISTORY

The Department of State Hospitals (DSH)-Patton is a secure forensic psychiatric hospital located in San Bernardino County. DSH-Patton was established in 1890 and opened in 1893. DSH-Patton provides treatment to forensically and civilly committed patients within secure treatment areas (STA's). The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,287 beds. In fiscal year (FY) 2022-23, DSH-Patton served 1,416 patients. The commitment categories of patients treated at DSH-Patton are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,570 employees work at DSH-Patton providing 24/7 care, including psychiatrists, psychologists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, registered dieticians, and other clinical staff. In addition, there are various non-level-of-care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The Trial Competency treatment along with the Court Preparation Project is for patients admitted to the hospital under Penal Code (PC) 1370 as Incompetent to Stand Trial. These patients receive a specialized constellation of treatment which is designed to specifically help the patient gain the knowledge and skills necessary to return to court. The goal is for the patient to understand court proceedings and effectively participate in their defense.

The focus of treatment for Offenders with a Mental Disorder (OMD) and Not Guilty by Reason of Insanity (NGI) population emphasizes the potential for each patient to learn new skills and adaptive coping mechanisms to manage symptoms of a mental illness, while also enhance the patient's awareness and insight into symptoms that led to dangerousness in the past. Other goals include motivation for treatment, development of social skills, understanding co-occurring disorders, independence in Activities of Daily Living (ADL), and helping patients to create an overall lifestyle of recovery from mental illness, addiction, and other co-morbid conditions. Treatment also focuses on improving patients' quality of life for preparation and eventual successful and effective transition to Community Outpatient Treatment (COT) or a less restrictive setting.

All treatment programs at DSH-Patton utilize the recovery philosophy as well as a Trauma-Informed Care approach, offering a broad spectrum of treatment, while fully endorsing the hospital's mission to provide comprehensive clinical services within the context of a biopsychosocial rehabilitation model within an environment of safety and security for all patients, staff, and the community in an atmosphere of dignity and respect.

Enhanced Treatment Program (ETP)

The ETP is designed to provide enhanced treatment in a secure setting for patients at the highest risk of most dangerous behavior. The ETP is intended to provide increased therapy opportunities within a structured, least restrictive environment. The ETP is to be utilized when safe treatment is not possible in a standard treatment environment. The pilot is driven by Assembly Bill 1340. The Budget Act of 2023 reported the project had been rephased while fire sprinkler redesign and State Fire Marshal approvals continue in other areas of the building.

The ETP model allows for enhanced staffing which includes a complement of Clinical, Nursing and Hospital Police Officer (HPO) staff. Classifications utilized include Staff Psychiatrist, Clinical Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse, and Psychiatric Technician.

ACCREDITATION AND LICENSURE

DSH-Patton is awarded the *Gold Seal of Approval* for achieving accreditation under the Hospital Accreditation Program (HAP) by The Joint Commission (TJC) recognized as an independent, not-for-profit organization and the largest standards-setting and accrediting body in healthcare. The HAP accreditation program is achieved upon successful completion of an on-site triennial survey attained by meeting rigorous performance standards, delivering the best quality care, and exhibiting a culture of excellence that inspires to continually improve performance. The hospital sustains accreditation with a mutual belief in patient and employee safety, effective care processes, patient outcomes using evidence-based practices, maintenance in environmental engineering controls, and, performance analysis studies, which are collectively woven into the fabric of our healthcare organization's operation. The hospital recognizes accreditation does not begin and end with an on-site survey, it is a continuous process of monitoring, communication, transparency, education and evaluating sustainability.

DSH-Patton is licensed as an Acute Psychiatric Hospital (APH) by the California Department of Public Health – Licensing and Certification Unit governed by the provisions of the Health and Safety Code of California and its rules and regulations to operate and maintain Acute Psychiatric Care and Intermediate Care bed classifications. Patton hospital meets the APH definition by demonstrating a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. DSH-Patton is licensed to provide services for 1,287 patients and with additional housing not to exceed total 1,530 patient beds in adherence to the Welfare and Institutions Code, Section 4107 (c) defining the joint plan between the California Department of Corrections and Rehabilitation and the State Department of Mental Health. DSH-Patton's licensing operation also includes Physical Therapy, Radiological Services, Social Services and Speech Pathology. The hospital maintains licensure through frequent on-site surveys that includes a robust review on the hospitals' safety, environment, effectiveness, and quality of healthcare, every three years for Acute units and two years for Intermediate Care units. Communication, education, performance improvement studies, quality improvement analysis and risk management awareness and interventions are additional priorities to the hospital's continued emphasis for optimal patient care and treatment.

DSH-PATTON MUSEUM

On April 17th, 2015, the DSH-Patton Museum opened its doors for the first time to the public. The on-site museum examines the history of psychiatric treatment in California state-run facilities and offers a glimpse of the evolution of mental health treatment during the last 127 years.

Patton accepted its first patients on August 1, 1893. The museum, only the second of its kind west of the Mississippi River, features more than 140 artifacts. Among the artifacts found in the museum are original medical and surgical equipment, firefighting equipment from the early part of the last century and nursing uniforms from the 1950s. It explores the complex and extensive history of Patton State Hospital, including its history as a general psychiatric hospital and the transition to a forensic facility. It avoids reinforcing stigma and attempts to be inclusive of the various individuals whose experiences are reflected in the hospital's past.

The museum itself is located on the grounds of the hospital in a 1920s cottage home that once was inhabited by hospital staff and their families. Since the museum's opening, numerous Southern Californians have visited for tours and researchers from as far away as South Africa have presented to experience the museum. The DSH-Patton Museum remains a valuable resource for state employees and members of the public by providing insight and information about an institution with deep local roots and a history that exemplifies the progression of mental health treatment in America.

TRAINING AND PARTNERSHIPS

DSH-Patton offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Patton's training programs.

DSH-Patton Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation
Pharmacy [1]	• Systemwide, DSH's pharmacy discipline is currently contracted with 13 pharmacy schools.
Psychiatric Technicians [2]	• 20/20 Psychiatric Technician Program
Psychiatry	• Loma Linda University Clerkship • Loma Linda University Forensic Psychiatry Residency • UC Riverside • Western University of Health Sciences • CA University of Science and Medicine
Psychology	• Practicum • American Psychological Association • Approved Pre-Doctoral Internship • Post-Doctoral Fellowship
Registered Dietitians	• Accredited Dietetic Internship
Rehabilitation Therapy	• Recreation Therapy (Student Assistants)
Social Work	• Master of Social Work Graduate Students (GSA Paid Internship) • Bachelor of Social Work Students (Volunteer Status)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 13 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North state University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (Stockton), Western University of Health Science, Chapman University, American University of Health Sciences School of Pharmacy, and Marshal B Ketchum College of Pharmacy.

[2] **Psychiatric Technicians:** 1. 20/20 Psychiatric Technician training programs are open to current employees that have been accepted into a Psychiatric Technician School. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

CALIFORNIA DEPARTMENT OF STATE HOSPITALS

REPORT ON STATE HOSPITAL FINANCIAL ACTIVITY

California Department of State Hospitals

FISCAL YEAR 2023-24

January 10, 2024

DIRECTOR
Stephanie Clendenin

EXECUTIVE SUMMARY

Pursuant of the Budget Act of 2023, the Department of State Hospitals (DSH) submits this report to the California State Legislature on the financial activity of the state hospitals. This report is prepared in accordance with Item 4440-011-0001, Provision 9 of the Budget Act of 2023 which requires DSH to provide a year-end summary and an operating budget for each state hospital with the fiscal year (FY) 2024-25 Governor's Budget and May Revision estimate. Specifically, this report includes the following information for each state hospital:

- The number of authorized and vacant positions for each institution
- The number of authorized and vacant positions for each institution, broken out by key classifications
- The number of authorized positions utilized in the temporary help blanket for each institution
- The 2022-23 year-end budget and expenditures by line-item detail for each institution
- The budgeted allocations for each institution for current and budget year
- The projected expenditures for current and budget years

DEPARTMENT OF STATE HOSPITALS OVERVIEW

DSH manages the nation's largest inpatient forensic mental health hospital system. The mission of DSH is to provide evaluation and treatment to patients in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. In addition to state hospital treatment, DSH provides services in contracted Jail-Based Competency Treatment (JBCT), Community-Inpatient Facilities (CIF), Conditional Release Program (CONREP), Community-Based Restoration (CBR), and pre-trial felony mental health Diversion programs. DSH is responsible for the daily care to over 7,000 patients. In FY 2022-23, DSH served over 13,000 patients, with 9,140 served across the state hospitals, 1,912 in JBCT, 207 in CIF, 620 in CBR contracted programs, and 794 in CONREP programs. 11,259 individuals were treated within a DSH inpatient program and 1,875 served through DSH's outpatient programs. Through Early Access Stabilization Services (EASS) and Re-Evaluation services, during FY 2022-23, DSH initiated services for 1,427 patients in EASS, and off ramped 546 through DSH's Re-Evaluation program. In addition, during FY 2022-23, 477 individuals were diverted from jail into county diversion programs funded by DSH.

SUMMARY OF AUTHORIZED AND VACANT POSITIONS

The following table provides a summary of the authorized and vacant positions for the state hospital system as of November 1, 2023.

State Hospital	Authorized Positions[1]	Vacant as of 11/1/2023	Vacancy Percent
Atascadero	2,344.6	568.8	24.3%
Coalinga	2,540.5	524.6	20.6%
Metropolitan	2,399.3	576.9	24.0%
Napa	2,754.5	661.7	24.0%
Patton	2,705.1	329.3	12.2%
Totals	**12,744.0**	**2,661.3**	**20.9%**

[1] Includes positions approved for Estimate Items Enhanced Treatment Program (21.0 in Patton) that will not be filled due to delays in activation and Metropolitan State Hospital Increased Secure Bed Capacity (51.1 in Metropolitan) that will not be filled due to SNF roof repairs as described in the 2024-25 Governor's Budget Estimate.

AUTHORIZED VERSUS VACANT POSITIONS BY CLASSIFICATION

As of November 1, 2023, DSH's vacancy rate is 20.9 percent. Item 4440-011-0001, Provision 9 requires DSH to provide the number of authorized and vacant classifications, including psychiatric technicians, nurses, physicians, psychiatrists, social workers, and rehabilitation therapists. The following table provides a summary of the authorized and vacant positions for those classifications.

		Atascadero		Coalinga		Metropolitan		Napa		Patton	
Class Title	Class Code	Authorized	Vacant	Authorized	Vacant	Authorized[1]	Vacant	Authorized	Vacant	Authorized[1]	Vacant
Staff Psychiatrist	7619	33.5	23.5	34.3	24.3	67.3	37.3	55.4	7.7	66.5	35.0
Psychologist	9873	45.0	12.0	35.7	21.7	43.0	10.0	51.4	10.9	65.3	13.7
Senior Psychiatric Technicia	8252	104.2	20.2	95.0	8.0	84.8	28.8	84.0	24.0	93.0	0.0
Rehabilitation Therapist	Various	53.4	11.4	46.0	10.0	60.0	17.8	67.1	5.1	76.3	17.1
Registered Nurse	8094	244.4	58.4	235.9	32.3	294.1	64.1	461.2	93.8	362.1	13.1
Clinical Social Worker	9872	47.7	19.7	47.0	20.0	64.7	20.7	64.2	15.5	77.0	11.0
Psychiatric Technician	8253	675.8	207.8	721.5	196.5	497.5	156.5	469.8	147.4	750.3	79.3
Physician/Surgeon	7552	17.5	0.0	25.2	16.2	26.4	2.0	26.8	0.0	31.0	5.0

[1] Includes positions approved for Estimate Items Enhanced Treatment Program (21.0 in Patton) that will not be filled due to delays in activation and Metropolitan State Hospital Increased Secure Bed Capacity (51.1 in Metropolitan) that will not be filled due to SNF roof repairs as described in the 2024-25 Governor's Budget Estimate.

TEMPORARY HELP BLANKET POSITIONS

Temporary help blanket positions are utilized to offset vacancies and overtime. The following table provides a summary of authorized temporary help blanket positions for the state hospitals as of November 1, 2023.

Authorized Blanket Positions	
Atascadero	30.1
Coalinga	28.0
Metropolitan	67.2
Napa	47.5
Patton	81.2
Total	**254.0**

STATE HOSPITAL ALLOCATIONS AND EXPENDITURES

Exhibit I (attached) provides detail on the budget and expenditures for all five state hospitals and each facility individually, listed by FI$Cal account code for FY 2022-23. For FY 2023-24 and FY 2024-25, Exhibit II (attached) displays the projected budget and expenditures for all five hospitals and each facility individually. Any anticipated savings due to delayed projects or unit activations have been reflected in these allocations and projected expenditures.

Exhibit I—All Hospitals[1]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$748,981,000	$739,340,000
	5100150-Earnings - Temporary Civil Service Employees	$31,986,000	$31,503,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$107,874,000	$106,430,000
Salaries and Wages Total		**$888,841,000**	**$877,273,000**
Staff Benefits	5150150-Dental Insurance	$992,000	$980,000
	5150200-Disability Leave - Industrial	$14,840,000	$14,666,000
	5150210-Disability Leave - Nonindustrial	$3,306,000	$3,261,000
	5150350-Health Insurance	$21,774,000	$21,505,000
	5150400-Life Insurance	$61,000	$61,000
	5150450-Medicare Taxation	$12,986,000	$12,821,000
	5150500-OASDI	$8,277,000	$8,173,000
	5150600-Retirement - General	$202,948,000	$200,347,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$357,000	$352,000
	5150750-Vision Care	$190,000	$187,000
	5150800-Workers' Compensation	$65,427,000	$64,581,000
	5150900-Staff Benefits - Other	$151,850,000	$149,966,000
Staff Benefits Total		**$483,009,000**	**$476,901,000**
Operating Expenses and Equipment	5301400-Goods - Other	$4,300,000	$4,243,000
	5302900-Printing - Other	$918,000	$908,000
	5304800-Communications - Other	$2,296,000	$2,266,000
	5306700-Postage - Other	$205,000	$202,000
	5308900-Insurance - Other	$687,000	$679,000
	5320490-Travel - In State - Other	$1,710,000	$1,688,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$1,069,000	$1,056,000
	5324350-Rents and Leases	$53,797,000	$53,018,000
	5326900-Utilities - Other	$29,553,000	$29,202,000
	5340330-Consulting and Professional Services – Inter - Other	$3,799,000	$3,748,000
	5340580-Consulting and Professional Services - External - Other	$117,941,000	$116,429,000
	5344000-Consolidated Data Centers	$46,000	$46,000
	5346900-Information Technology - Other	$396,000	$392,000
	5368115-Office Equipment	$17,352,000	$17,114,000
	5390900-Other Items of Expense - Miscellaneous	$87,676,000	$86,544,000
	5415000-Claims Against the State	$16,000	$16,000
	5490000-Other Special Items of Expense	$2,144,000	$2,111,000
Operating Expenses and Equipment Total		**$323,908,000**	**$319,665,000**
Grand Total		**$1,695,758,000**	**$1,673,839,000**

[1]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Atascadero State Hospital[2&3]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$149,069,000	$146,612,000
	5100150-Earnings - Temporary Civil Service Employees	$4,891,000	$4,810,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$18,435,000	$18,131,000
Salaries and Wages Total		**$172,395,000**	**$169,553,000**
Staff Benefits	5150150-Dental Insurance	$165,000	$162,000
	5150200-Disability Leave - Industrial	$2,703,000	$2,658,000
	5150210-Disability Leave - Nonindustrial	$1,262,000	$1,241,000
	5150350-Health Insurance	$4,296,000	$4,225,000
	5150400-Life Insurance	$12,000	$12,000
	5150450-Medicare Taxation	$2,442,000	$2,402,000
	5150500-OASDI	$1,736,000	$1,707,000
	5150600-Retirement - General	$40,436,000	$39,769,000
	5150700-Unemployment Insurance	$63,000	$62,000
	5150750-Vision Care	$38,000	$37,000
	5150800-Workers' Compensation	$16,637,000	$16,363,000
	5150900-Staff Benefits - Other	$25,281,000	$24,864,000
Staff Benefits Total		**$95,071,000**	**$93,502,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,276,000	$1,255,000
	5302900-Printing - Other	$140,000	$138,000
	5304800-Communications - Other	$505,000	$497,000
	5306700-Postage - Other	$36,000	$35,000
	5308900-Insurance - Other	$31,000	$30,000
	5320490-Travel - In State - Other	$376,000	$370,000
	5322400-Training - Tuition and Registration	$205,000	$202,000
	5324350-Rents and Leases	$33,022,000	$32,478,000
	5326900-Utilities - Other	$3,798,000	$3,735,000
	5340330-Consulting and Professional Services – Inter - Other	$1,083,000	$1,065,000
	5340580-Consulting and Professional Services - External - Other	$24,463,000	$24,060,000
	5344000-Consolidated Data Centers	$14,000	$14,000
	5346900-Information Technology - Other	$68,000	$67,000
	5368115-Office Equipment	$1,928,000	$1,896,000
	5390900-Other Items of Expense - Miscellaneous	$14,972,000	$14,725,000
	5490000-Other Special Items of Expense	$22,000	$22,000
Operating Expenses and Equipment Total		**$81,939,000**	**$80,589,000**
Grand Total		**$349,405,000**	**$343,644,000**

[2]Budget and expenditure do not include reimbursements or reappropriations.
[3]Includes Hospital Police Academy.

Exhibit I—Coalinga State Hospital[4]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$164,704,000	$163,339,000
	5100150-Earnings - Temporary Civil Service Employees	$824,000	$817,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$24,787,000	$24,582,000
Salaries and Wages Total		**$190,315,000**	**$188,738,000**
Staff Benefits	5150150-Dental Insurance	$229,000	$227,000
	5150200-Disability Leave - Industrial	$4,152,000	$4,118,000
	5150210-Disability Leave - Nonindustrial	$803,000	$796,000
	5150350-Health Insurance	$4,927,000	$4,886,000
	5150400-Life Insurance	$15,000	$15,000
	5150450-Medicare Taxation	$2,696,000	$2,674,000
	5150500-OASDI	$2,049,000	$2,032,000
	5150600-Retirement - General	$47,315,000	$46,923,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$101,000	$100,000
	5150750-Vision Care	$42,000	$42,000
	5150800-Workers' Compensation	$13,011,000	$12,903,000
	5150900-Staff Benefits - Other	$31,623,000	$31,361,000
Staff Benefits Total		**$106,964,000**	**$106,078,000**
Operating Expenses and Equipment	5301400-Goods - Other	$744,000	$738,000
	5302900-Printing - Other	$312,000	$309,000
	5304800-Communications - Other	$669,000	$663,000
	5306700-Postage - Other	$51,000	$51,000
	5308900-Insurance - Other	$74,000	$73,000
	5320490-Travel - In State - Other	$471,000	$467,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$176,000	$175,000
	5324350-Rents and Leases	$3,590,000	$3,560,000
	5326900-Utilities - Other	$6,924,000	$6,867,000
	5340330-Consulting and Professional Services – Inter - Other	$300,000	$298,000
	5340580-Consulting and Professional Services - External - Other	$40,387,000	$40,052,000
	5344000-Consolidated Data Centers	$2,000	$2,000
	5346900-Information Technology - Other	$37,000	$37,000
	5368115-Office Equipment	$4,025,000	$3,992,000
	5390900-Other Items of Expense - Miscellaneous	$24,230,000	$24,029,000
	5415000-Claims Against the State	$15,000	$15,000
	5490000-Other Special Items of Expense	$46,000	$46,000
Operating Expenses and Equipment Total		**$82,056,000**	**$81,377,000**
Grand Total		**$379,335,000**	**$376,193,000**

[4]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Metropolitan State Hospital[5]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$95,594,000	$95,475,000
	5100150-Earnings - Temporary Civil Service Employees	$4,791,000	$4,785,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$9,443,000	$9,431,000
Salaries and Wages Total		**$109,828,000**	**$109,691,000**
Staff Benefits	5150150-Dental Insurance	$163,000	$163,000
	5150200-Disability Leave - Industrial	$1,491,000	$1,489,000
	5150210-Disability Leave - Nonindustrial	$236,000	$236,000
	5150350-Health Insurance	$3,236,000	$3,232,000
	5150400-Life Insurance	$9,000	$9,000
	5150450-Medicare Taxation	$1,798,000	$1,796,000
	5150500-OASDI	$1,103,000	$1,102,000
	5150600-Retirement - General	$25,134,000	$25,103,000
	5150700-Unemployment Insurance	$38,000	$38,000
	5150750-Vision Care	$27,000	$27,000
	5150800-Workers' Compensation	$8,588,000	$8,577,000
	5150900-Staff Benefits - Other	$24,529,000	$24,499,000
Staff Benefits Total		**$66,352,000**	**$66,271,000**
Operating Expenses and Equipment	5301400-Goods - Other	$471,000	$470,000
	5302900-Printing - Other	$141,000	$141,000
	5304800-Communications - Other	$54,000	$54,000
	5306700-Postage - Other	$31,000	$31,000
	5308900-Insurance - Other	$135,000	$135,000
	5320490-Travel - In State - Other	$209,000	$209,000
	5322400-Training - Tuition and Registration	$161,000	$161,000
	5324350-Rents and Leases	$3,012,000	$3,008,000
	5326900-Utilities - Other	$4,380,000	$4,375,000
	5340330-Consulting and Professional Services – Inter - Other	$437,000	$436,000
	5340580-Consulting and Professional Services - External - Other	$8,735,000	$8,724,000
	5344000-Consolidated Data Centers	$8,000	$8,000
	5346900-Information Technology - Other	$11,000	$11,000
	5368115-Office Equipment	$1,102,000	$1,101,000
	5390900-Other Items of Expense - Miscellaneous	$8,536,000	$8,525,000
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$93,000	$93,000
Operating Expenses and Equipment Total		**$27,517,000**	**$27,483,000**
Grand Total		**$203,697,000**	**$203,445,000**

[5]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Napa State Hospital[6]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$162,969,000	$160,904,000
	5100150-Earnings - Temporary Civil Service Employees	$6,747,000	$6,661,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$27,022,000	$26,679,000
Salaries and Wages Total		**$196,738,000**	**$194,244,000**
Staff Benefits	5150150-Dental Insurance	$235,000	$232,000
	5150200-Disability Leave - Industrial	$5,124,000	$5,059,000
	5150210-Disability Leave - Nonindustrial	$459,000	$453,000
	5150350-Health Insurance	$4,893,000	$4,831,000
	5150400-Life Insurance	$12,000	$12,000
	5150450-Medicare Taxation	$2,871,000	$2,835,000
	5150500-OASDI	$1,604,000	$1,584,000
	5150600-Retirement - General	$43,423,000	$42,872,000
	5150700-Unemployment Insurance	$81,000	$80,000
	5150750-Vision Care	$42,000	$41,000
	5150800-Workers' Compensation	$13,539,000	$13,367,000
	5150900-Staff Benefits - Other	$34,760,000	$34,319,000
Staff Benefits Total		**$107,043,000**	**$105,685,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,035,000	$1,022,000
	5302900-Printing - Other	$109,000	$108,000
	5304800-Communications - Other	$829,000	$818,000
	5306700-Postage - Other	$40,000	$39,000
	5308900-Insurance - Other	$380,000	$375,000
	5320490-Travel - In State - Other	$234,000	$231,000
	5322400-Training - Tuition and Registration	$283,000	$279,000
	5324350-Rents and Leases	$11,512,000	$11,366,000
	5326900-Utilities - Other	$8,991,000	$8,877,000
	5340330-Consulting and Professional Services – Inter - Other	$1,347,000	$1,330,000
	5340580-Consulting and Professional Services - External - Other	$18,971,000	$18,730,000
	5346900-Information Technology - Other	$265,000	$262,000
	5368115-Office Equipment	$5,005,000	$4,942,000
	5390900-Other Items of Expense - Miscellaneous	$18,791,000	$18,553,000
	5490000-Other Special Items of Expense	$976,000	$964,000
Operating Expenses and Equipment Total		**$68,768,000**	**$67,896,000**
Grand Total		**$372,549,000**	**$367,825,000**

[6]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Patton State Hospital[7]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$176,645,000	$173,010,000
	5100150-Earnings - Temporary Civil Service Employees	$14,733,000	$14,430,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$28,187,000	$27,607,000
Salaries and Wages Total		**$219,565,000**	**$215,047,000**
Staff Benefits	5150150-Dental Insurance	$200,000	$196,000
	5150200-Disability Leave - Industrial	$1,370,000	$1,342,000
	5150210-Disability Leave - Nonindustrial	$546,000	$535,000
	5150350-Health Insurance	$4,422,000	$4,331,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$3,179,000	$3,114,000
	5150500-OASDI	$1,785,000	$1,748,000
	5150600-Retirement - General	$46,640,000	$45,680,000
	5150700-Unemployment Insurance	$74,000	$72,000
	5150750-Vision Care	$41,000	$40,000
	5150800-Workers' Compensation	$13,652,000	$13,371,000
	5150900-Staff Benefits - Other	$35,657,000	$34,923,000
Staff Benefits Total		**$107,579,000**	**$105,365,000**
Operating Expenses and Equipment	5301400-Goods - Other	$774,000	$758,000
	5302900-Printing - Other	$216,000	$212,000
	5304800-Communications - Other	$239,000	$234,000
	5306700-Postage - Other	$47,000	$46,000
	5308900-Insurance - Other	$67,000	$66,000
	5320490-Travel - In State - Other	$420,000	$411,000
	5322400-Training - Tuition and Registration	$244,000	$239,000
	5324350-Rents and Leases	$2,661,000	$2,606,000
	5326900-Utilities - Other	$5,460,000	$5,348,000
	5340330-Consulting and Professional Services – Inter - Other	$632,000	$619,000
	5340580-Consulting and Professional Services - External - Other	$25,385,000	$24,863,000
	5344000-Consolidated Data Centers	$22,000	$22,000
	5346900-Information Technology - Other	$15,000	$15,000
	5368115-Office Equipment	$5,292,000	$5,183,000
	5390900-Other Items of Expense - Miscellaneous	$21,147,000	$20,712,000
	5490000-Other Special Items of Expense	$1,007,000	$986,000
Operating Expenses and Equipment Total		**$63,628,000**	**$62,320,000**
Grand Total		**$390,772,000**	**$382,732,000**

[7]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit II—All Hospitals[8]

	2023-24 Budget	2024-25 Budget	2023-24 Projected Expenditure	2024-25 Projected Expenditure
4410010-Atascadero	$405,127,000	$414,177,000	$401,075,730	$410,035,230
4410020-Coalinga	$422,150,000	$432,023,000	$417,928,500	$427,702,770
4410030-Metro	$267,625,000	$274,903,000	$264,948,750	$272,153,970
4410040-Napa	$417,134,000	$421,980,000	$412,962,660	$417,760,200
4410050-Patton	$449,153,000	$455,891,000	$444,661,470	$451,332,090
Grand Total	**$1,961,189,000**	**$1,998,974,000**	**$1,941,577,110**	**$1,978,984,260**

[8]Budget and expenditure do not include reimbursements or reappropriations.

STATE HOSPITALS
HOSPITAL POLICE OFFICER/STATE HOSPITAL POLICE ACADEMY
Provisional Language Reporting

BACKGROUND

The Budget Act of 2023 includes provisional language stating:

"The State Department of State Hospitals shall provide a status update on the recruitment and retention of hospital police officers, to be included in the department's 2024–25 Governor's Budget estimate and subsequent May Revision estimate. The update shall include the number of authorized and vacant positions for each hospital, the actual attrition rate for the 2023–24 fiscal year, the projected attrition rate for the 2024–25 fiscal year, and the rate of success pertaining to the number of hospital police officer cadet graduates of the OPS Police Academy."

Hospital Police Officer Positions

The table below displays the status of Hospital Police Officers (HPO) authorized positions as of October 1, 2023:

HPO Authorized Positions[1] as of October 1, 2023				
Hospitals	Filled	Vacant	FTE[2]	Vacancy Rate
Atascadero	117.0	14.0	131.0	10.69%
Coalinga	185.0	37.0	222.0	16.67%
Metropolitan[3]	107.0	35.3	142.3	24.81%
Napa	98.0	59.9	157.9	37.94%
Patton	58.0	1.0	59.0	1.69%
Total	565.0	147.2	712.2	20.67%

[1] Only includes classification 1937 – Hospital Police Officer
[2] Authorized Positions as of October 2023
[3] DSH-Metropolitan vacancies include 42.0 positions related to Increased Secure Bed Capacity (ISBC). This space is being used temporarily to provide interim housing for Skilled Nursing Facility (SNF) patients while the SNF building is under repair for extensive water damage. DSH anticipates the SNF building will be reactivated May 2024

Hospital Police Officer Attrition Rate

The table below displays the projected HPO attrition rates as of October 1, 2023, based on actual attrition rates and trends for fiscal years (FYs) 2021-22, 2022-23, and 2023-24:

HPO Attrition Rates as of October 1, 2023					
Hospitals	FY 2023-24 FTE[4]	FY 2023-24 Attrition Rate[5]	Average Estimated Monthly Positions	FY 2024-25 Attrition Rate[6]	Average Estimated Monthly Positions
Atascadero	131.0	1.11%	1.5	1.30%	1.7
Coalinga	222.0	0.58%	1.3	0.47%	1.0
Metropolitan	142.3	0.97%	1.4	0.88%	1.3
Napa	157.9	0.72%	1.1	0.54%	0.8
Patton	59.0	1.20%	0.7	1.33%	0.8
Total	**712.2**	**0.92%**	**6.0**	**0.90%**	**5.6**

Cadet Graduation Rates

The table below displays actual graduation rates from cohorts conducted from FY 2017-18 through the present:

OPS Cadet Graduation Rates				
Academy	Academy Dates	Cadets Attended	Cadets Graduated	Graduation Rate
Academy 27	(02/12/18 – 05/18/18)	50	44	88.0%
Academy 28	(08/13/18 – 11/16/18)	49	42	85.7%
Academy 29	(10/01/18 – 01/10/19)	38	32	84.2%

[4] Authorized Positions as of October 2023
[5] Projected attrition rate based on FY 2021-22, 2022-23, and 2023-24 data
[6] Projected attrition rate based on FY 2021-22, 2022-23, and 2023-24 data

Academy 30	(02/11/19 – 05/31/19)	33	31	93.9%
Academy 31	(08/12/19 – 11/22/19)	43	34	79.1%
Academy 32	(12/02/19 – 03/20/20)	19	17	89.5%
Academy 33	(02/10/20 – 05/22/20)	20	16	80.0%
Academy 34	(08/24/20 – 12/10/20)	25	21	84.0%
Academy 35	(12/28/20 – 04/22/21)	19	10	52.6%
Academy 36	(05/03/21 – 08/12/21)	16	9	56.3%
Academy 37	(08/23/21 – 12/09/21)	10	4	40.0%
Academy 38	(12/28/21 – 04/17/22)	15	11	73.3%
Academy 39	(05/02/22 – 08/11/22)	24	18	75.0%
Academy 40	(08/23/22 – 12/08/22)	16	14	87.5%
Academy 41	(12/28/22 – 04/13/23)	22	19	86.4%
Academy 42	(05/01/23 – 08/15/23)	18	15	83.3%
Academy 43	(08/28/23 - 12/12/23)	16	TBD	TBD
	Total[7]	**417**	**337**	**80.8%**

HPO Recruitment Efforts

In December 2021, the Office of Protective Services (OPS) established a contract with Cooperative Personnel Services (CPS) to assist with recruitment efforts and increase the number of HPO applications received. This cooperative effort is ongoing. As part of a digital marketing campaign, both Facebook and Google

[7] Not including Academy 43, scheduled to end December 12, 2023

advertisements are utilized to increase awareness and leads for DSH to engage with prospective candidates. In addition, DSH continues to conduct online virtual Career Fairs, and create videos and other media advertisements to broadcast and increase awareness of DSH peace officer employment opportunities. Advertisements are frequently refreshed to continue to attract new applicants.

While the contract with CPS has been successful in increasing the numbers of applicants who take the entry exam, DSH is also exploring opportunities with CPS on how to increase the number of candidates who successfully make it from entry exam application to academy acceptance. To increase availability, DSH converted their exam process from a proctored, in-person exam to a non-proctored, online exam. The non-proctored, online exam successfully went live on September 28, 2023. As of November 3, 2023, 329 candidates passed the online exam and 265 applications for HPO positions have been received. All candidates are contacted; those who have applied and passed the exam are moved to the background process, those who have passed the online exam are contacted to submit an application, and those who have applied and not taken the exam are directed to the exam process. These numbers represent a higher percentage of candidates taking the exam and applying for HPO positions. The goal of the streamlined, continuous online exam is to increase recruitment numbers and accelerate the recruitment process.

DSH will continue to work on HPO recruitment efforts and provide an update in the 2024-25 May Revision.

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
An Annual Report to the Fiscal and Policy Committees of the Legislature in Accordance with Section 4145(a) of the Welfare and Institutions Code (WIC)
Informational Only

EXECUTIVE SUMMARY

The Department of State Hospitals (DSH) was authorized by Assembly Bill 1340 (Achadjian, Statutes of 2014) to establish pilot Enhanced Treatment Programs (ETP) for patients determined to be at the highest risk for dangerous behavior against other patients and hospital staff and who cannot be safely treated in a standard treatment environment. The ETP provides treatment with the intent to return patients to a standard treatment environment with supports to prevent future aggression, increase safety, and protect patients and staff from harm.

DSH was originally authorized to establish four ETP units, totaling 49 beds. Three 13-bed units were to be provided at DSH-Atascadero, and one 10-bed treatment unit would be at DSH-Patton. One unit at DSH-Atascadero began admitting patients on September 14, 2021. As the remaining three units are not yet completed or activated, this report covers activity for the operation of the first activated ETP unit at DSH-Atascadero, in accordance with reporting requirements established in AB 1340.[1]

This report encompasses data collected between September 14, 2021, and September 30, 2023. For comparison, it also presents data for the first year of ETP activation (September 14, 2021, to September 30, 2022), as well as data for the second year of activation (October 1, 2022, to September 30, 2023). The data shows patient characteristics including gender, ethnicity, age on admission, legal group, and years at DSH. Data also includes information on staffing requirements and staff-to-patient ratios, as well as staff turnover. Data on restraint and seclusion use and serious injuries is also provided. The report also includes information regarding patients' rights complaints received as provided by the Disability Rights California, California Office of Patients' Rights, and the resolution to these issues. Finally, the report includes information regarding training provided to ETP staff, as well the training offered to staff who are primarily assigned to other units but could be asked to provide support in the ETP.

[1] Status updates on the construction and activation of each unit is provided in DSH's annual Governor's Budget and May Revision Population and Caseload Estimates (see Section C2).

Recommendations based on the findings are outlined at the conclusion of this report.

BACKGROUND

Assembly Bill 1340 (Achadjian, Statutes of 2014) authorized DSH to establish pilot ETP for those patients determined to be at highest risk for dangerous behavior against other patients and hospital staff and who cannot be safely treated in a standard treatment environment The ETP provides treatment and support intended to return patients to a standard treatment environment and prevent future aggression, while increasing safety in the facility and protecting patients and staff from harm. As such, the ETP provides enhanced treatment, staffing, and security, and implements admissions and treatment planning processes to identify and address patients' violence risk factors.

This report covers program activity since activation of the first activated ETP unit at DSH-Atascadero, in accordance with reporting criteria established in AB 1340. Specifically, Section 4145 of the Welfare and Institutions Code reads:

> *4145. (a) The State Department of State Hospitals shall monitor the pilot enhanced treatment programs (ETP), evaluate outcomes, and report on its findings and recommendations. This report shall be provided to the fiscal and policy committees of the Legislature annually, beginning on January 10 of the first year after which the first ETP is opened and services have commenced, and shall be in compliance with Section 9795 of the Government Code. The evaluation shall include, but is not limited to, all of the following:*
>
> *(1) Comparative summary information regarding the characteristics of the patients served.*
> *(2) Compliance with staffing requirements.*
> *(3) Staff classification to patient ratio.*
> *(4) Average monthly occupancy.*
> *(5) Average length of stay.*
> *(6) The number of residents whose length of stay exceeds 90 days.*
> *(7) The number of patients with multiple stays.*
> *(8) The number of patients whose discharge was delayed due to lack of available beds in a standard treatment environment.*
> *(9) Restraint and seclusion use, including the number of incidents and duration, consistent with paragraph (3) of subdivision (d) of Section 1180.2 of the Health and Safety Code.*
> *(10) Serious injuries to staff and residents.*

(11) Serious injuries to staff and residents related to the use of seclusion and restraints as defined under Section 1180 of the Health and Safety Code.
(12) Staff turnover.
(13) The number of patients' rights complaints, including the subject of the complaint and its resolution.
(14) Type and number of trainings provided for ETP staff.
(15) Staffing levels for ETPs.

In response to the reporting requirements as identified in Section 4145, DSH has established data tracking and collection methodologies to capture the information required. This report details the methodology used and describes the data captured for the collection period ending on September 30, 2023. The data contained in this report is limited to what is permitted under the Health Insurance Portability and Accountability Act (HIPAA), and state privacy laws, when disclosure of health information is required by law. (45 CFR 164.512(a); Civ. Code, § 56.10, subd. (b)(9).)

I. Methodology

This reporting period encompasses data collected between September 14, 2021, and September 30, 2023. In addition to cumulative data, this report also presents data for the reporting period from September 14, 2021, to September 30, 2022 (Period 1), as well as data for the reporting period from October 1, 2022, to September 30, 2023 (Period 2). Existing DSH enterprise data collection practices were relied upon for reporting of items identified in Section 4145(a) (1-12) and (14-15). The requested information was operationalized considering current DSH policy and procedures. Data was collected using existing software and was independently verified using tracking sheets developed specifically for this reporting requirement.

Data related to Section 4145(a)(13) was provided by the Disability Rights California, California Office of Patients' Rights. DSH contracts with the California Office of Patients' Rights, a Disability Rights California unit, to provide patients' rights advocacy services at the state hospitals.

II. Summary of Data

Patient Characteristics

Gender	Period 1 N%[a]	Period 2 N%[a]	ETP Total N (%)[b]
Male	*** (***%)	<11 (***%)	19 (100%)
Female[c]	0 (0%)	0 (0%)	0 (0%)

[a] Admissions per reporting period.

[b] Total patients served.

[c] The DSH-Patton ETP unit designed to serve female patients is under construction.

Ethnicity[a, b]	Period 1 N (%)	Period 2 N (%)	ETP Total N (%)	DSH Patients (%)[a]	DSH Population (%)	CA Population (%)
Asian	<11 (***%)	<11 (***%)	<11 (***%)	4%	2.6%	16%
Black or African American	<11 (***%)	<11 (***%)	<11 (***%)	26%	26.3%	6%
Hispanic or Latino	<11 (***%)	<11 (***%)	<11 (***%)	29%	29.9%	40%
White	<11 (***%)	<11 (***%)	<11 (***%)	37%	35.7%	35%
Other Non-White/Unknown	<11 (***%)	<11 (***%)	<11 (***%)	4%	5.5%	3%

[a] Data represents DSH inpatients only. Data sources: Business Intelligence Center (BIC) reports managed by the DSH Data Management Office (DMO), and the U.S. Census Bureau (https://www.census.gov/quickfacts/fact/table/CA).

[b] Total patients served per reporting period.

[1] Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Age	Period 1 N (%)	Period 2 N(%)	ETP N (%)	DSH N (%)
18-29	<11 (***%)	<11 (***%)	<11 (***%)	493 (9%)
30-41	<11 (***%)	<11 (***%)	*** (***%)	1,556 (28%)
42-53	<11 (***%)	<11 (***%)	***(***%)	1,272 (23%)
54-65	0 (0%)	0 (0%)	0 (0%)	1,419 (26%)
66-77	0 (0%)	0 (0%)	0 (0%)	723 (13%)
78-90	0 (0%)	0 (0%)	0 (0%)	*** (***%)
91+	0 (0%)	0 (0%)	0 (0%)	<11 (***%)
Mean Age (years)	41.25	39.0	40.84	48.91

Legal Group	Period 1 N(%)	Period 2 N(%)	ETP N (%)	DSH N (%)[a]
Incompetent to Stand Trial	<11 (***%)	<11 (***%)	<11 (***%)	1,740 (31%)
Not Guilty by Reason of Insanity	<11 (***%)	<11 (***%)	<11 (***%)	1,207 (22%)
Offender with a Mental Disorder	<11 (***%)	<11 (***%)	<11 (***%)	998 (18%)
Lanterman-Petris-Short Act	<11 (***%)	<11 (***%)	<11 (***%)	570 (10%)
Sexually Violent Predator	<11 (***%)	<11 (***%)	<11 (***%)	943 (17%)
Coleman[b]	0 (0%)	0 (0%)	0 (0%)	105 (2%)

[a] DSH residents' information on census as of 9/30/2023.

[b] Per Enhanced Treatment Program Emergency Regulations (California Code of Regulations, Title 9, Division 1, Chapter 17, Article 2, Section 4900), a patient may be referred to the Enhanced Treatment Program if there is no existing contract or memorandum of understanding that provides alternative and clinically appropriate treatment outside of DSH. Coleman patients are eligible for treatment in the CDCR Psychiatric Inpatient Programs.

Years at DSH[a] – Current Admission[b]	Period 1 N (%)	Period 2 N (%)	ETP N (%)	DSH N(%)[c]
0-5	11 (69%)	<11 (***%)	12 (63%)	3,651 (66%)
6-10	<11 (***%)	<11 (***%)	<11 (***%)	693 (12%)
11-15	0 (0%)	0 (0%)	0 (0%)	522 (9%)
15 -20	<11 (***%)	<11 (***%)	<11 (***%)	385 (7%)
20-25	0 (0%)	0 (0%)	0 (0%)	148 (3%)
25+	0 (0%)	0 (0%)	0 (0%)	164 (3%)
Mean (years):	5.75	5.65	5.64	5.96

[a] This data captures years at DSH *prior* to ETP Admission.

[b] "Current admission" includes hospital years during most recent commitment that did not result in a discharge from DSH.

[c] DSH residents' information on census as of 9/30/2023.

Years at DSH[a] – Overall[b]	Period 1 N (%)	Period 2 N (%)	ETP N (%)
0-5	<11 (***%)	<11 (***%)	<11 (***%)
6-10	<11 (***%)	<11 (***%)	<11 (***%)
11-15	<11 (***%)	<11 (***%)	<11 (***%)
15 -20	<11 (***%)	<11 (***%)	<11 (***%)
20-25	<11 (***%)	<11 (***%)	<11 (***%)
25+	0 (0%)	0 (0%)	0 (%)
Mean (years):	9.38	8.48	9.05

[a] This data captures years at DSH *prior* to ETP Admission.
[b] "Overall" includes hospital years during all DSH commitments. Individuals committed to DSH may have had multiple commitment periods during their lifetime.

All patients (residents) currently or formerly admitted to the ETP are male. A unit that can accommodate female patients is currently under construction with an estimated activation in May 2024. ETP patient (residents) mean age is 40.84 years, which is about 8 years below the DSH-wide age average. ETP patients (residents) come from, Asian, Black or African American, Hispanic or Latino, White, and Other or Unknown ethnic backgrounds. The ethnic distribution of ETP patients (residents) closely matches that of DSH in general, though differs from the overall CA population. The primary legal commitment for patients (residents) in the ETP are: Not Guilty by Reason of Insanity (NGI), Offenders with Mental Disorders (OMD), Incompetent to Stand Trial (IST), Sexually Violent Predators (SVP), and Lanterman-Petris-Short (LPS) Act Conservatees. Compared to the overall DSH population, the ETP serves a higher percentage of LPS patients (residents) and a lower percentage of IST and SVP patients (residents). Since their most recent DSH admission, ETP patients (residents) have spent an average of 5.64 years at DSH, which is equitable to the average length of stay (ALOS) through DSH at 5.96 years. However, as some ETP patients (residents) have been admitted to DSH on multiple occasions, the combined average time spent in DSH is 9.05 years. There is no DSH systemwide comparison statistic available for length of stay across different admissions.

Compliance with Staffing Requirements

According to Health and Safety Code 1265.9(d)(1), the ETP shall maintain a staff-to-patient ratio of one to five. Health and Safety Code 1265.9(g) defines staff as licensed nurses and psychiatric technicians providing direct patient care.

During the reporting period from September 14, 2021, through September 30, 2023, the ETP maintained a staff-to-patient ratio of one to five or lower. This ratio stayed consistent across Period 1 (September 14, 2021 – September 30, 2022) and Period 2 (October 1, 2022 – September 30, 2023).

Staff Classification to Patient Ratio

Section 4144(e)(3) of the Welfare and Institutions Code defines a multidisciplinary treatment team as "*consisting of a psychologist, a psychiatrist, a nurse, a psychiatric technician, a clinical social worker, a rehabilitation therapist and any other necessary staff…*". The ETP staff also includes Hospital Police Officers to assist with movement of patients to and from treatment within and outside the ETP Unit.

Section 4144(l)(3) of the Welfare and Institutions Code defines an FNAT Psychologist as "*Forensic Needs Assessment Team" or "FNAT" means a panel of psychologists with expertise in forensic assessment or violence risk assessment, each of whom are assigned an ETP case or group of cases.*"

Staff Classification	Staff-to-Patient Ratio[a]
Level-of-Care Staff[b]	
AM Shift	1 : 1.5
PM Shift	1 : 1.5
NOC Shift	1 : 3.0
Hospital Police Officer	1 : 6.5
Rehabilitation Therapist	1 : 6.5
Psychologist	1 : 6.5
Psychiatrist	1 : 13.0
Social Worker	1 : 13.0
FNAT Psychologist	1 : 6.5

[a] This ratio stayed consistent across Period 1 (September 14, 2021 – September 30, 2022) and Period 2 (October 1, 2022 – September 30, 2023).
[b] Level of Care staff include Psychiatric Technicians and Registered Nurses.

Occupancy

Average Monthly Occupancy	N
September 2021	<11
October 2021	<11
November 2021	<11
December 2021	12.52
January 2022	11.97
February 2022	11.50
March 2022	11.00
April 2022	<11
May 2022	<11
June 2022	11.80
July 2022	12.39
August 2022	13.00
September 2022	13.00
October 2022	13.00
November 2022	13.00
December 2022	13.00
January 2023	13.00

February 2023	12.50
March 2023	13.00
April 2023	12.13
May 2023	12.00
June 2023	12.13
July 2023	13.00
August 2023	13.00
September 2023	12.50
Average	11.68

Average Length of Stay	Period 1 Days[b]	Period 2 Days	Cumulative Days[a]
DSH- Atascadero Unit 29 Current Patients	292.85 ± 111.54	304.75 ± 115.20	543.83 (± 268.75)
DSH-Atascadero Unit 29 Discharged Patients	132.33 ± 73.51	244.25 ± 104.00	330.29 (± 230.28)
Total	262.75 ± 121.90	289.63 ± 112.37	465.16 ± 270.22

[a] Days are full days and (Standard Deviation).
[b] Period 1 included 382 days, while Period 2 included 365 days.

Other Occupancy	Cumulative N[a]	Period 1 N	Period 2 N
The number of patients (residents) whose length of stay exceeds 90 days.	17	14	15
The number of patients (residents) with multiple ETP stays.	0	0	0
The number of patients (residents) whose discharge was delayed due to lack of available beds in a standard treatment environment.	0	0	0

[a] The cumulative number will be less than Periods 1 and 2 combined since many patients were present in ETP during both periods,

The ETP began accepting patients on September 14, 2021. Since then, there have been a total of 19 admissions and less than 11 discharges. Between September 14, 2021, and September 30, 2022, there were 16 admissions and less than 11 discharges. Between October 1, 2022, and September 30, 2023, there were less than 11 admissions and less than 11 discharges.

At the end of this reporting period on September 30, 2023, there were 12 patients (residents) on the unit. 17 patients' (residents') length of stay exceeded 90 days during the reporting period. Of those patients (residents), less than 11 have been discharged. No patient (resident) had multiple ETP stays. None of these discharges were delayed due to lack of available beds in a standard treatment environment.

Restraint and Seclusion Use

Patients (residents) may be placed in seclusion or restraint for being an imminent danger to themselves or to others.

Over the reporting period from September 14, 2021, to September 30, 2022, there were less than 11 incidents of seclusion and 92 incidents of ambulatory and non-ambulatory restraints. 44 incidents of seclusion or restraint during that reporting period were related to patients (residents) being deemed an imminent danger to others, while 53 incidents of seclusion or restraint incidents were related to imminent danger to self. Of the 92 incidents of ambulatory and non-ambulatory restraints, 84 involved 5-point bed restraint (non-ambulatory restraints). Less than 11 incidents of ambulatory restraints lasted for 6.56 hours. Non-ambulatory restraint usage lasted for a combined 914.15 hours. These 84 restraint incidents involved less than 11 of 16 patients, however less than 11 of those less than 11 patients accounted for 47 (55%) of the incidents and 689.84 (75%) of the total restraint hours. The less than 11 incidents of seclusion that occurred during that period involved less than 11 patients for a total of 9.13 hours. There have been no incidents of seclusion during subsequent reporting periods.

Over the following period from October 1, 2022, to September 30, 2023, there were 21 incidents of non-ambulatory g restraints. Less than 11 incidents of non-ambulatory restraint use during the reporting period were related to patients (residents) being deemed an imminent danger to others, while 16 incidents of seclusion or restraint were related to imminent danger to self. The total time of non-ambulatory restraint use was 424.08 hours. There were no incidents of ambulatory restraint usage or seclusion during that period.

Cumulatively, since activating the ETP on September 14, 2021, to the end of this reporting period on September 30, 2023, there were less than 11 incidents of seclusion and 113 incidents of both ambulatory and non-ambulatory restraints, for a total of 118 seclusion and restraint episodes. 49 (42%) incidents of seclusion or restraint during the cumulative period were related to patients (residents) being deemed an imminent danger to others, while 69 (58%) incidents of seclusion or restraint were related to imminent danger to self. A total of less than 11 incidents of seclusion involved less than 11[2] patients for a total of 9.13 hours. These incidents occurred prior to September 30, 2022, and there has been no seclusion use since. Since activation, 105 incidents of 5-point bed restraint (non-ambulatory) occurred in ETP. 5-point restraint usage lasted for a combined 1,338.18 hours. These 105 restraint incidents involved less than 11 of 19 patients. Less than 11 (44%) of these less than 11 patients accounted for 81(77%) of these incidents and 1,188.16 (89%) of the total restraint hours. There were also less than 11 incidents of ambulatory restraint use which lasted for a combined total of 6.56 hours. There have been no ambulatory restraint hours since the end of the September 2022 reporting period. Less than 11 patients accounted for 236.35 (18%) of the total non-ambulatory restraint hours.

Restraint and Seclusion Use	Period 1		Period 2		Cumulative	
	N[a]	Duration[b]	N[a]	Duration[b]	N[a]	Duration[b]
Seclusion	<11	9.13	0	0.00	<11	9.13
Ambulatory Restraint	<11	6.56	0	0.00	<11	6.56
Non-Ambulatory Restraint	84	914.10	21	424.08	105	1338.18
Total	97	929.79	21	424.08	118	1353.87

[a] Number of distinct incidents that required seclusion or restraint of a patient.
[b] Total time in hours.

Non-Ambulatory Restraint Frequency and Duration[a]									
	Period 1			Period 2			Cumulative		
	N[b]	%	Duration [c]	N[b]	%	Duration [c]	N[b]	%	Duration [c]
Danger to Others	33	39%	262.43	<11	***%	226.76	38	21.5%	489.19
Danger to Self	51	61%	651.67	16	76%	197.32	67	68.5%	848.99

[2] The 2023 Legislative Report erroneously stated that the incident of seclusion involved less than 11 patients. This was due to a calculation error. For the reporting period covering the 2023 Legislative Report only less than 11 patients were placed in seclusion. This number did not change for the current reporting period.

[a] Non-ambulatory Restraint while patient is located in the ETP Unit.
[b] Number of distinct incidents requiring non-ambulatory restraint of a patient.
[c] Time in hours.

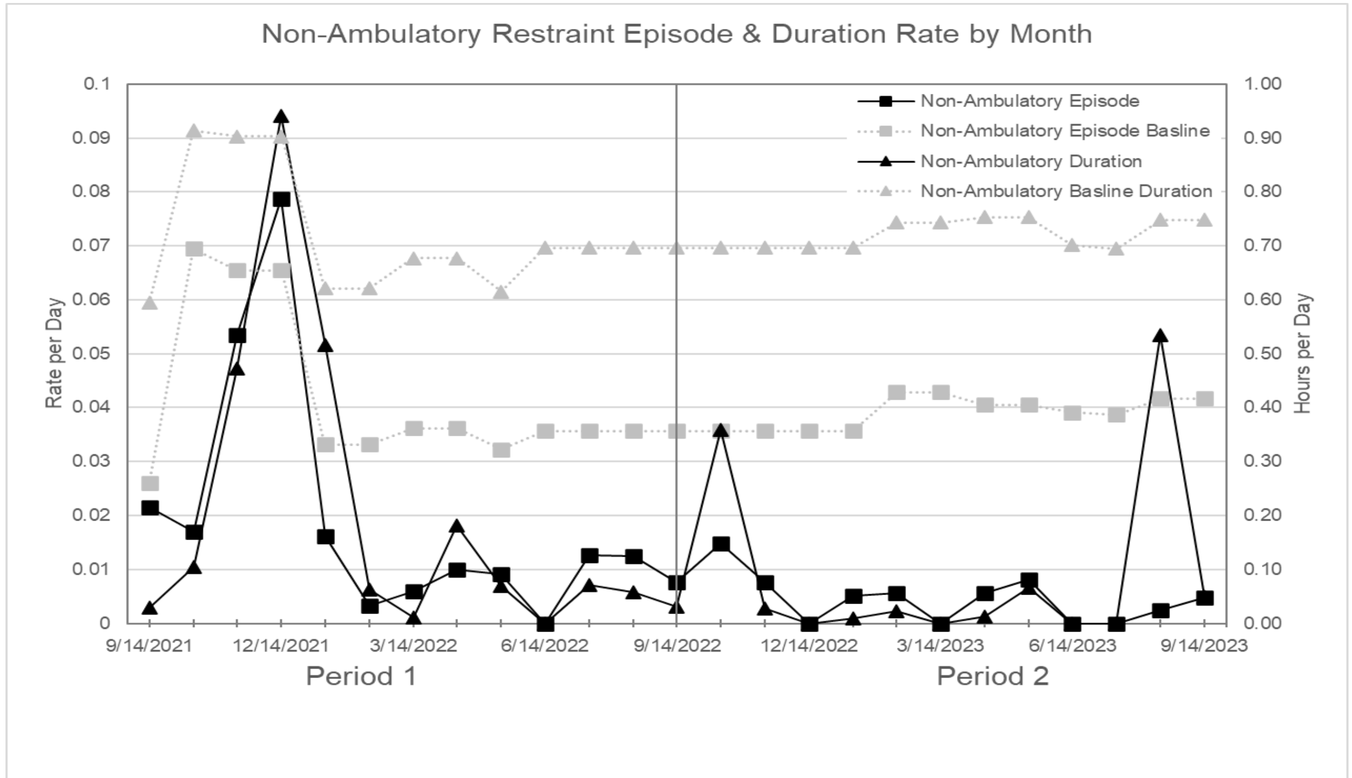
Rates of ETP patient (resident) non-ambulatory restraint use per month were obtained for the six months prior to ETP admission and were compared to non-ambulatory restraint. During both reporting periods rates for frequency and duration of non-ambulatory restraint use significantly decreased after patients were admitted to the ETP. For the combined period between September 14, 2021, and September 30, 2023, placement in the ETP resulted in a decrease in the rates of frequency and duration of non-ambulatory restraint use. Specifically, frequency of non-ambulatory restraint use decreased by 79.22%, while the duration of non-ambulatory restraint use decreased by 80.53%. These findings align with the goal of the ETP to provide less restrictive care by reducing the frequency and duration of non-ambulatory restraint use.

Non-Ambulatory Restraint Rate and Duration Prior to ETP vs. During ETP Admission											
Period 1[a]						Period 2[b]					
Prior to ETP Admission			During ETP Admission			Prior to ETP Admission			During ETP Admission		
N[c]	Rate[d]	Duration[e]	N[c]	Rate[d]	Duration[e]	N[c]	Rate[d]	Duration	N[c]	Rate[d]	Duration
162	0.0619	2342.96	84	0.0200	914.10	104	0.0398	1779.83	21	0.0045	424.08

[a] Period 1 covers September 14, 2021, to September 30, 2022.
[b] Period 2 covers October 1, 2022, to September 30, 2023.
[c] Number of distinct incidents requiring non-ambulatory restraint of a patient.
[d] Rates of aggression are calculated per 1 patient day.
[e] Time in hours.

Non-Ambulatory Restraint Rate and Duration Prior to ETP vs. During ETP Admission					
Cumulative[a]					
Prior to ETP Admission			During ETP Admission		
N[b]	Rate[c]	Duration[d]	N[b]	Rate[c]	Duration[d]
190	0.0600	2585.76	105	0.0119	1338.18

[a] Cumulative data covers September 14, 2021, to September 30, 2023.
[b] Number of distinct incidents requiring non-ambulatory restraint of a patient.
[c] Rates of aggression are calculated per 1 patient day.
[d] Time in hours.



Serious Injuries to Staff and Patients (Residents)

Serious injuries to staff and patients (residents) were defined based on DSH Policy Directive #9500, Incident Management System. Injuries that met the following criteria are reported in the data below:

> *"Medical Treatment Required: The injury received is severe enough to require medical treatment (medical treatment beyond first aid and other than diagnostic of assessment; i.e. sutures, broken bones, may include new prescriptions specific to the treatment related to the injury sustained in the incident, beyond over-the-counter medication) by a licensed medical physician, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization; further, the treatment received may be provided within the facility or provided outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital."*

> *"Hospitalization Required: The injury received is so severe that it requires medical intervention and treatment as well as care of the injured patient at a*

general acute care hospital outside the facility; this severity level requires that the injured patient be formally admitted to the hospital and assigned to a bed on a unit outside of the emergency room."

Based on this definition there were 12 aggressive incidents that resulted in serious injuries to staff between September 14, 2021, and September 30, 2022. None of these incidents resulted in serious injuries requiring hospitalization. During that review period, there were less than 11 incidents of patient (resident) aggression to self that resulted in serious patients (residents) injuries. None of these injuries required hospitalization. There were no aggressive acts to other patients resulting in injury during the review period.

Between October 1, 2022, and September 30, 2023, less than 11 aggressive incidents resulted in serious injury to staff. None of these injuries required hospitalization. There were less than 11 serious injuries to patients (residents) that were the result of self-injury. None of these incidents required hospitalization. There were no aggressive acts to other patients resulting in serious injury during the review period.

Cumulatively, since activation of the ETP on September 14, 2021, to September 30, 2023, there were 16 aggressive incidents resulting in serious injury to staff. None of these injuries required hospitalization. There were less than 11 serious injuries to patients (residents) as a result of patient aggression to self. None of these incidents required hospitalization. There were no aggressive acts to other patients resulting in serious injury during the review period.

Serious injury to staff and patients (residents) related to the use of seclusion and restraint was defined per Health and Safety Code 1180.1 (g), "*Serious injury*" *means significant impairment of the physical condition as determined by qualified medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs*."

Based on this definition the first reporting period dating from September 14, 2021, through September 30, 2022, included no injuries to staff or patients as the result of restraint use. Between October 1, 2022, and September 30, 2023, less than 11 patients (residents) and 1 staff member were injured as the result of restraint use, both individuals were injured during the stabilization process. The patient was not placed in full bed restraints following this incident.

To summarize, there were a total of 26 serious injuries that occurred since activation of the ETP on September 14, 2021, to September 30, 2023. There were 16 aggressive incidents resulting in serious injury to staff (as defined by Policy Directive #9500) during

that period. There were less than 11 serious injuries to staff (as defined by Health and Safety Code 1180.1(g)) that was related to the use of seclusion or restraint. There were less than 11 incidents of patient aggression to self that resulted in serious injuries to patients (residents) (as defined by Policy Directive #9500.). Less than 11 incidents of serious patient injury (defined by Health and Safety Code 1180.1(g)) occurred during stabilization of the patient (resident). None of these 26 incidents required hospitalization. There were no aggressive acts to other patients (residents) resulting in serious injury during the review period.

Serious Injuries	**Period 1 N**	**Period 2 N**	**Cumulative N**
Serious Injuries to Staff[a]	***	<11	***
Serious Injuries to Patients (Residents)[a]	<11	<11	<11
Serious injuries to Staff related to the use of seclusion and restraints[b,c]	0	<11	<11
Serious injuries to Patients (Residents) related to the use of seclusion and restraints[b,c]	0	<11	<11
Serious Injuries to Patients (Residents) as a result of self-injurious behavior[a,d]	<11	<11	<11
Total:	18	<11	26

[a] Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.
[b] Serious injury as defined by Health and Safety Code 1180.1(g).
[c] These injuries occurred during stabilization and containment. The patient was not placed in full-bed restraints following this incident.
[d] Injuries due to self-harm behaviors are not included in the total, as they are accounted for in the overall frequency count for serious injuries to patients (residents).

For each reporting period rates of patient aggression toward self and others, as well as resulting injuries were collected. These variables were also collected for each patient in the six months prior to ETP admission. This allowed for calculation of rates of change following admission to the ETP.

Rates of Aggression and Injury Prior to ETP vs. During ETP Admission[a]										
	Period 1[b]					Period 2[c]				
	Prior to ETP Admission		During ETP Admission			Prior to ETP Admission		During ETP Admission		
	N	Rate	N	Rate	Change[e]	N	Rate	N	Rate	Change[e]
Physical Aggression towards Staff	149	0.0569	124	0.0295	-49%	90	0.0344	41	0.0088	-75%

Physical Aggression towards Peers	68	0.0260	13	0.0031	-88%	62	0.0237	<11	0.0009	-96%
Serious Injuries to Staff[d]	14	0.0053	12	0.0029	-45.3	12	0.0046	<11	0.0011	-76%
Serious Injuries to Peers[d]	<11	0.0015	0	0.0000	-100%	<11	0.0015	0	0.0000	-100%
Physical Aggression towards Self	17	0.0065	42	0.0100	+54%	15	0.0057	39	0.0084	+47%
Serious Injuries towards Self[d]	<11	0.0004	<11	0.0014	+274%	<11	0.0004	<11	0.0004	+13%

[a] Rates of aggression are calculated per 1 patient day.
[b] Period 1 covers September 14, 2021, to September 30, 2022
[c] Period 2 covers October 1, 2022, to September 30, 2023
[d] Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.
[e] Percent change is calculated from non-rounded values.

Cumulative Rates of Aggression and Injury Prior to ETP vs. During ETP Admission[a,b]					
	Prior to ETP Admission		During ETP Admission		Cumulative Rate of Change
	N	Rate	N	Rate	
Physical Aggression towards Staff	239	0.0529	165	0.0187	-65%
Physical Aggression towards Peers	130	0.0307	17	0.0019	-94%
Serious Injuries[c] of Staff	26	0.0055	17	0.0020	-63%
Serious Injuries[c] of Peers	<11	0.0017	0	0.0000	-100%
Physical Aggression towards Self	32	0.0066	81	0.0092	38%
Serious Injuries towards Self[c]	<11	0.0003	<11	0.0009	187%

[a] Rates of aggression are calculated per 1 patient day.
[b] Cumulative data covers September 14, 2021, to September 30, 2023.
[c] Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.

Cumulative results covering the period from September 14, 2021, to September 30, 2023, show a 94% reduction in frequency of aggressive acts towards peers, and a 65% reduction in frequency of aggressive acts towards staff. Furthermore, the severity of injuries resulting from these aggressive acts decreased by 100% for patient to patient (resident) aggression. The severity of injuries to staff decreased by 63%. This data highlights that the ETP is meeting its goal for reduction of severe physical aggression towards both staff and patients. Rates of physical aggression towards self increased while patients were on the ETP, as did the injuries that occurred as a result. less than 11 of the 19 ETP patients were responsible for the less than 11 self-harm incidents that occurred in the period covering September 14, 2021, to September 30, 2023. 50% (less than 11) of these less than 11 incidents were committed by less than 11 patients.

Staff Turnover

During the reporting period from September 14, 2021, through September 30, 2022, 4.0 registered nurses (RNs) left the ETP; 2.0 nurses left employment at the facility and 2.0 nurses transferred to other units within the facility. During this same time period, 15.0 psychiatric technicians left the ETP; 1.0 promoted to a position outside the ETP, 7.0 left employment at the facility and 7.0 transferred to other units within the facility. During that reporting period, 4.0 RNs were hired to the ETP as well as 4.0 psychiatric technicians. 7.0 psychiatric technicians transferred into the ETP from other units within the facility.

During the reporting period of October 1, 2022, through September 30, 2023, 4.0 RNs left the ETP; 2.0 nurse left employment with the facility and 2.0 nurse transferred to other unit within the facility. During this same time period 10.0 psychiatric technicians left the ETP; 2.0 promoted to positions outside the ETP, 3.0 left employment with the facility and 5.0 transferred to other units within the facility. During this reporting period, 1.0 psychiatric technician was hired into the ETP, and 11.0 psychiatric technicians transferred in from other units within the facility.

Cumulatively, from activation of the ETP on September 14, 2021, through the end of this most recent reporting period on September 30, 2023, 8.0 RNs left the ETP; 2.0 nurses retired, 2.0 nurses transferred to other units within the facility, 1.0 nurse left the facility and 3.0 nurses left state service. During this same time period, 21.0 psychiatric technicians, including 2.0 senior psychiatric technicians, left the ETP; 12.0 transferred to other units inside the facility, 2.0 psychiatric technicians retired, 1.0 transferred to another facility within DSH and 8.0 left the facility for other employment outside of DSH. During this reporting period the ETP hired 4.0 new RNs, and 5.0 new psychiatric

technicians. 16.0 psychiatric technicians, including 3.0 senior psychiatric technicians, transferred into the ETP from other units in the facility.

Changes in clinical staff first occurred within the period of October 1, 2022, to September 30, 2023. 1.0 social worker left the ETP to transfer to another unit, and 0.75 social worker transferred into the ETP (Note: This occurred in August 2023 and the new social worker is providing 0.25 coverage on another unit temporarily. Recruitment is in process for additional social work resources). 1.0 Psychologist retired from state service, and 0.9 Senior Supervising Psychologist transferred into the unit to provide coverage. During this period 2.0 FNAT psychologists left the ETP. One FNAT psychologist left state service, and the other transferred to another division within DSH. One FNAT psychologist was hired. The remaining FNAT psychologist position was providing temporary relief (filling behind another psychologist on family leave) and was not refilled.

Patients' Rights Complaints

The Disability Rights California, California Office of Patients' Rights provided information pertaining to patients' rights complaints received for each reporting period. For the cumulative period of September 14, 2021, through September 30, 2023. A total of 75 complaints were made by 12 patients (residents).

	Period 1[a]		Period 2[b]		Cumulative[c]	
Complaint Category	**Patients[d]**	**Complaints[e]**	**Patients**	**Complaints**	**Patients**	**Complaints**
Access / Use of Personal Possessions	<11	<11	<11	<11	<11	<11
Advocacy Services	<11	<11	0	0	<11	<11
Confidentiality, records, etc.	0	0	<11	<11	<11	<11
Conservatorship	<11	<11	0	0	<11	<11
Daily Living	<11	<11	<11	<11	<11	<11
Dignity / Privacy / Respect / Human Care	<11	<11	<11	<11	<11	15
Free from Harm	0	0	<11	<11	<11	<11
Keep / Spend Reasonable Sum of Money / Personal Funds	<11	<11	0	0	<11	<11
Legal	<11	<11	<11	<11	<11	<11
Medical Care and Treatment	<11	<11	<11	<11	<11	<11
Medication Side Effects	<11	<11	0	0	<11	<11

Mental Health Treatment	<11	<11	<11	<11	<11	<11
Patient Withdrew the Complaint	<11	<11	<11	<11	<11	<11
Physical Abuse	<11	<11	0	0	<11	<11
Physical Exercise/Recreation / Out of Doors	<11	<11	0	0	<11	<11
Religious Freedom and Practice	<11	<11	0	0	<11	<11
Social Interaction / Participation	<11	<11	0	0	<11	<11
Telephones / Confidential Use	<11	<11	0	0	<11	<11
Treatment Services Promoting Independence	<11	<11	0	0	<11	<11
Unable to read, to understand or unrelated	<11	<11	0	0	<11	<11
Visitors / Visiting Space	<11	<11	<11	<11	<11	<11
TOTAL PATIENTS[d]	11	61	<11	21	12	82

[a] Period 1 covers September 14, 2021, to September 30, 2022.
[b] Period 2 covers October 1, 2022, to September 30, 2023.
[c] Cumulative data covers September 14, 2021, to September 30, 2023.
[d] Total number of 19 patients making complaints.
[e] Total complaints made may include multiple complaints by one patient.

Access / Use of Personal Possessions

- Less than 11 complaints were regarding wanting a laptop, wanting a radio returned, access to money and personal property from transfer, missing personal items after transfer, and wanting personal papers/legal paperwork returned.
    - Resolution: The Patients' Rights Advocate (PRA) resolved most complaints by informing patients about items deemed to be contraband on the ETP, working with staff to gain access to personal property, and confirmation from patient or staff that the item(s) were back in the patient's possession.

Advocacy Services

- Less than 11 complaints were regarding patients not satisfied with ETP placement hearing and personal property.
    - Resolution: The PRA discussed and provided information on the purpose of the ETP referral, admission criteria, and the ETP screening process, along with the acceptable personal property items list. The PRA also

raised concerns the patient had with DSH regarding the patient feeling they were not adequately heard in the hearing. Patient was informed of the current laws and regulations outlining the ETP Forensic Needs Assessment Panel (FNAP) placement evaluation meetings and certification process.

Confidentiality, records, etc.

- Less than 11 complaints were regarding patients being potentially unable to do a Chart Review before his ETP one-year continuation hearing.
    - Resolution: The PRA worked with the patient and the Health Information Management Department (HIMD) to ensure request to access records was received, processed, and provided by HIMD before the ETP hearing.

Conservatorship

- Less than 11 complaints were regarding conservatorship hearings and not receiving information about how to participate in the hearings.
    - Resolution: The PRA provided information on a mental health conservatorship (WIC 5361-5364) and confirmed that the patient had the Handbook for Challenging Mental Health Conservatorships that the Patients' Rights office provided earlier in the year. The PRA spoke with the social worker who stated they would be working with the conservator and the appointed attorney to facilitate communication with the patient.

Daily Living

- Less than 11 complaints were regarding cold water not working, wanting more activities on the unit, and wanting a haircut.
    - Resolution: The PRA resolved most concerns during phone and/or in-person conversations with the patient. Patient informed the PRA that advocacy efforts resulted in approval for his future haircuts to have the option to be done off unit where he can get a styled cut, if he chooses. The PRA informed patient that as soon as current quarantine is lifted, the Barbershop can be scheduled to visit the unit.

Dignity / Privacy / Respect / Humane Care

- 15 complaints were regarding being disrespected by staff.
    - Resolution: The PRA resolved these complaints by communicating with the unit supervisor to help find resolutions for these issues.

Free from Harm

- Less than 11 complaints were regarding feeling threatened by a Hospital Police Officer on the unit.
  - Resolutions: The PRA referred patient to the complaint process regarding State Hospital Police Officers and provided the appropriate form. The patient was advised about the Office of Protective Services (OPS) complaint process and did not reach out to PRA for follow-up.

Keep / Spend Reasonable Sum of Money / Personal Funds

- Less than 11 complaints were regarding tax forms, Canteen Bucks, access to personal funds, vocational assignment pay, not being taken to The Grill by staff, and a Canteen order refund.
  - Resolution: The PRA spoke with the patients who informed them that the issue(s) were resolved. The PRA provided the requested tax forms, information on how to earn Canteen Bucks as a treatment incentive, informed the patients of what staff to contact regarding their vocational pay, and the PRA provided claim forms and process for Canteen refunds.
  - Resolution: The PRA contacted the patients' psychologist regarding the patients' desire to go to The Grill. The patients were informed to work with his treatment team on the requirements to access The Grill, which is considered a high-risk area, as there are safety requirements that need to be met before The Grill could be included in their behavior plan. The PRA confirmed that the patient is still able to spend money through the Canteen once per week.

Legal

- Less than 11 complaints were regarding wanting to be transferred, not being satisfied with their legal representation, and their LPS conservatorship.
  - Resolution: The PRA spoke with each patient and provided them with information and materials in the areas of concern.

Medical Care and Treatment

- Less than 11 complaints were regarding pro re nata (PRN) "as needed" medications, dental needs not being met, pain medication, experiencing physical pain, and needing corrective lenses.
  - Resolution: The PRA confirmed that patients were able to visit the dentist and resolve their dental issues, provided self-advocacy tools for patient to use in future situations in regard to PRNs, process to request alternative pain medication, process for medical referrals, and confirmed pending eye appointment when unit comes off of quarantine.

Medication Side Effects

- Less than 11 complaints were regarding medication side effects.
  - Resolution: The PRA advised patient(s) to speak with their nurse or psychiatrist directly to work on resolutions to medication side effects. The PRA communicated with unit staff and continued to monitor patient during the following weeks. The patient stated the medication dosage was lowered and no longer had concerns about medication side effects.

Mental Health Treatment

- Less than 11 complaints were regarding treatment team meetings and treatment for sex offenders on the ETP.
  - Resolution: The PRA confirmed patients were receiving mental health treatment while on ETP that would help meet discharge goals. The PRA met with patient to confirm the staff are giving him reminders of treatment team meetings.

Patient Withdrew the Complaint

- Less than 11 complaints were regarding groups, phones not working, not being informed of medical treatment, not being seen by the Podiatrist, not being able to go in the day room, and not being able to shower.
  - Resolution: The PRA spoke with the patients, the patients confirmed that the issues had resolved and withdrew the complaint.

Physical Abuse

- Less than 11 complaints were regarding wanting to sue a state prison for abuse.
  - Resolution: The PRA, with patient approval, filed an abuse report (SOC341) and provided a copy to the patient. The PRA provided legal contact information as well as educated patient on what next steps will be taken and suggested for him to talk with hospital police (DPS) with any follow up.

Physical Exercise / Recreation / Out of Doors

- Less than 11 complaints were regarding safety from another patient in the courtyard.
  - Resolution: The PRA communicated with staff and was informed that a safety plan has been created for these patients and that these patients will remain separate from the other patient while in the courtyard.

Religious Freedom and Practice

- Less than 11 complaints were regarding wanting to see the Chaplain.
  - Resolution: The PRA informed the patient of the unit's process for patients to request religious services and that group religious services were temporarily suspended due to the facility wide COVID-19 prevention measures.

Social Interaction (<11) and Participation and Telephones / Confidential Use (<11)

- Less than 11 complaints were regarding having a movie night on Sunday, telephones not working, and getting in touch with family.
  - Resolution: The PRA determined that these patients have access to movie night on Saturdays and that patients' requests for Sunday afternoon interferes with Unit Schedule (medication pass and physical assessments). The PRA confirmed that the telephones were repaired, and patients were able to contact family. The PRA will monitor telephone system during regular unit visits and ensure that information is posted of how to use the new telephone system.

Treatment Services Promoting Independence

- Less than 11 complaints were regarding not wanting to be on the ETP unit and would like to get magazines and acquire a General Educational Diploma (GED).
  - Resolution: The PRA spoke with these patients and resolved these issues. The PRA discussed that DSH, including ETP, does not offer GED services because it is an internet-based program, but instead provides the High School Equivalency Test (HiSET). Patients were referred to their treatment team to request a referral to educational services.

Unable to read, to understand, or unrelated

- Less than 11 complaints were regarding requests that the PRA give their letters to the nurse.
  - Resolution: The nurse received the letters per patients' request.

Visitors / Visiting Space

- Less than 11 complaints were regarding not being allowed to have a video call with girlfriend.
  - Resolution: The PRA informed the patients that it is his visitor's responsibility to contact the DSH-Atascadero Executive Director to ask for an exception to the Administrative Directive if they are a former employee of DSH.

ETP Staff Training

In addition to mandated training provided to all hospital staff, those providing care on the ETP receive specialized training. Employees whose primary work assignment is elsewhere in the hospital, but who may be asked to provide treatment coverage on the ETP also receive an orientation to working on the ETP.

In anticipation of ETP activation, 57 ETP staff participated in a six-week in-person training academy in April and May 2019 aimed at providing specialized skills to address the needs of the patient populations served through the ETP. Training was offered with a focus on evidence-based treatments to address common risk factors for violence. Due to delays in activation and the COVID-19 pandemic, another abbreviated two-week training academy was held virtually in April 2021 for 57 staff. The data below details the training topics presented during the most recent training academy, held April 13, 2021, through April 30, 2021.

- ETP Background, Philosophy & Culture
- ETP Positive Psychology
- ETP Trauma Informed Care
- ETP Motivational Interviewing
- ETP Sensory Modulation
- ETP Admission and Discharge Process
- ETP New Admission Orientation Process
- ETP Cognitive Remediation
- ETP Milieu Management Skills (DBT)
- ETP Treatment of Criminogenic Risk
- ETP Transdisciplinary Approach
- ETP Discipline Specific Duties
- ETP Writing a Behavior Plan
- ETP Coping Skills and Unit Privileges
- ETP Specific Charting Requirements
- ETP Incident Management Overview
- ETP Risk Assessment Process & Application
- ETP Patient's Rights
- ETP Therapeutic Options
- ETP Therapeutic Strategies and Interventions Theory
- ETP Social Skills Training for Schizophrenia
- ETP Operational Processes

In addition, an abbreviated videotaped training was created for staff whose primary work assignment is the ETP, but who did not have the opportunity to attend the full ETP academy. 21 staff completed this video training during the reporting period of September 14, 2021, through September 30, 2022, and 13 staff completed this training during the reporting period of October 1, 2022, through September 30, 2023. Overall, 34 staff completed this video training since activation of the ETP on

September 14, 2021, through September 30, 2023. Courses recorded and provided to staff included:

- ETP Positive Psychology
- ETP Trauma Informed Care
- ETP Motivational Interviewing
- ETP Therapeutic Options
- ETP Transdisciplinary Approach
- ETP Social Skills Training for Schizophrenia
- ETP Risk Assessment Process & Application
- ETP Specific Charting Requirements
- ETP Operational Processes

Lastly, a one-hour orientation to working on the ETP was developed for those whose primary work assignment is elsewhere, but who may be asked to provide treatment coverage on the ETP. 565 staff completed this training prior to the activation of the ETP. 892 level-of-care (e.g., licensed nurses and psychiatric technicians) and clinical (e.g., psychiatrists, psychologists, social workers, rehabilitation therapists) staff completed this training during the reporting period of September 14, 2021, through September 30, 2022, and 160 completed it during the reporting period of October 1, 2022, through September 30, 2023. Courses provided included:

- ETP Positive Philosophy
- ETP Trauma Informed Care
- ETP Sensory Modulation
- ETP Milieu Management Plan
- ETP Structure and Processes

In August 2023, 14 level-of-care and 7 clinical staff members participated in a half-day resiliency training aimed at providing coping skills while working in a highly acute environment.

In addition to the formalized training outlined above, ETP team members received informal consultation from subject matter experts under contract with DSH. These consultants assisted ETP team members with honing their skills in the treatment of complex psychopathology and behavioral issues. Consultations provided included advanced psychopharmacology, Dialectical Behavior Therapy, Cognitive Behavioral Therapy for Psychosis, and Cognitive Remediation.

Staffing Levels for ETPs

The table below summarizes the number of staff permanently assigned to provide direct patient care on the ETP and their classifications. Included are positions currently filled, as well as those being actively recruited for at the end of each reporting period.

ETP Permanent[a] Staff				
	Perjod 1[b]		Period 2[c]	
	Filled	Vacant	Filled	Vacant
Registered Nurse	14	3	10	3
Psychiatric Technician (includes Senior Psychiatric Technician)	20	5	20	5
Licensed Vocational Nurse	1	0	1	0
Psychiatrist	1	0	1	0
Psychologist	2	0	.9[d]	1
Social Worker	1	0	.75[d]	.25
Rehabilitation Therapist	2	0	2	0
FNAT Psychologist	3	0	2	0
Hospital Police Officers	9	0	9	0
Unit Supervisor	1	0	1	0

[a] Staff permanently assigned to the ETP, not including coverage to meet required staff-to-patient ratios.
[b] Staff vacancies as of September 30, 2022.
[c] Staff vacancies as of September 30, 2023.
[d] Staff are also assigned duties/coverage outside of the ETP.

FINDINGS AND RECOMMENDATIONS

Review of the data suggests areas of opportunity for ETP operations.

The ETP was conceived of as an environment to manage aggression, with units designed and constructed with environmental controls to allow for management of aggression outside of restraint use. A foremost goal of the ETP is to reduce the use of restraints. During this reporting period from September 14, 2021, through September 30, 2023, 35% of non-ambulatory restraint use was related to aggressive acts towards staff, which is a 7% reduction from the first year of ETP operations, spanning from September 14, 2021, through September 30, 2021. 69% of restraint use was related to self-injurious behavior, which presents a 7% increase from the first year of ETP operations. Less than 11 of the 19 ETP patients were responsible for 80% of restraint use.
Of note is that 50 (47%) of the 105 non-ambulatory restraint incidents occurred within the first three months of activation. During the first three months of activation, staff were still getting accustomed to utilizing the unique features and treatment enhancements of the ETP. Consequently, staff were educated about ETP-specific procedures of locking the patient room door as a less restrictive alternative to manage aggressive behavior.

Compared to the first year of ETP operations, DSH has noticed a significant decrease in the use of non-ambulatory restraints. While there were 84 non-ambulatory restraint episodes between September 14, 2021, to September 30, 2023, there were only 21 non-ambulatory restraint episodes between September 14, 2021, to September 30, 2023. During the last reporting period, the ETP referral process was adjusted to increase screening for self-injurious behavior. While this approach has significantly reduced the need for non-ambulatory restraints, the aim is to further develop staff skills in treating patients who are at risk for self-injurious behavior to reduce the need for restraints and utilize the unique features of the ETP environment instead.

This data supports the ETP is successful in meeting its goals for reduction of severe physical aggression towards others, as well as reduction of non-ambulatory restraint use. Patients engage in significantly less aggression towards others after being admitted to the ETP compared to when they received care in the standard treatment environment. Following ETP admission, the rates of aggressive incidents towards staff decreased by 64.69%, while aggressive acts towards other patients decreased by 93.74%. Patients also are placed in non-ambulatory restraints less frequently and for shorter periods of time after being placed in the ETP. Furthermore, the data highlights that the frequency of severe physical violence and the use of restraint has decreased even more over the course of ETP operations. In sum, this demonstrates that the ETP is meeting the stated objectives for reduction of violence and restraint use compared to treatment in the standard treatment environment. However, it also highlights that the ETP clinicians and staff have become more proficient in using their skills to further reduce the incidents of severe physical violence as well as restraint use since ETP activation.

An additional goal is to continue to address ongoing staff recruitment and retention. This objective is addressed within the DSH statewide strategic plan goal towards organizational and operational excellence. Examples of specific efforts to address workforce challenges are outlined below. While not specific to the ETP, this concentrated focus to recruit a talented workforce and create centers of professional training and excellence at the state hospitals will broaden the potential applicant pool for ETP positions. For further information on recruitment and retention efforts, please see the Report on Mental Health Services Staffing (section G5).

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL (IST) DIVERSION PROGRAM
SUPPLEMENTAL REPORTING LANGUAGE
Informational Only

BACKGROUND

The Budget Act of 2019 added the following Provisional Language:

> *Item 4440-011-0001—Department of State Hospitals 1. Incompetent to Stand Trial Diversion Program. Trial courts shall work with the Judicial Council to provide data pursuant to mental health diversion programs set forth in Penal Code section 1001.36 including the number of petitions that were granted. When possible, the courts shall also report the (1) number of petitions that were denied (2) number of petitions denied because the defendant did not meet the statutory requirements for eligibility, (3) number of individuals who successfully completed the diversion program, and (4) number of individuals that were terminated from the program. The Judicial Council will make this data available to the Legislature and the Department of State Hospitals on an annual basis commencing July 1, 2020. The Department of State Hospitals shall include this report in the data elements it receives from counties that have contracted with the department for mental health diversion programs funded pursuant to Chapter 6.5 (commencing with Section 4361) of the Welfare and Institutions Code.*

In response to the Provisional Language, the Department of State Hospitals (DSH) and the Judicial Council worked to ensure the Superior Courts of California data related to Penal Code (PC) section 1001.36 is transmitted and incorporated into the county data sets collected from the pre-trial diversion program (per Welfare and Institutions Code (WIC) 4361). This report describes the methodologies employed by both departments to collect the data required by WIC 4361 and the Provisional Language, as well as challenges encountered. Additionally, a high-level summary of the data collected as of June 30, 2023, is provided.

2024-25 GOVERNOR'S BUDGET REPORT

Judicial Council Data Collection Methodology

Pursuant to the Supplemental Report of the 2019 Budget Act regarding Assembly Bill 1810 (Stats. 2018, Ch. 34), trial courts are required to work with the Judicial Council of California to provide data pursuant to mental health diversion programs set forth in PC 1001.36. The Judicial Council is to make this data available to the Legislature and DSH on an annual basis, beginning January 1,

2020. In response to those requirements, the Judicial Council amended its quarterly superior court data surveys to include requests for totals of petitions for mental health diversion, petition outcomes, and program outcomes. These items were further amended to distinguish between petitions and diversions for cases including at least one felony charge and total petitions and diversions.

Below is a list of mental health diversion data requested by Judicial Council:

- Number of petitions received for pretrial mental health diversion pursuant to PC 1001.36
- Number of petitions received for pretrial mental health diversion pursuant to PC 1001.36 for individuals charged with at least one felony
- Number of pretrial mental health diversion petitions granted
- Number of pretrial mental health diversion petitions granted for individuals charged with at least one felony
- Number of pretrial mental health diversion petitions denied
- Number of pretrial mental health diversion petitions denied for individuals charged with at least one felony
- Number of petitions for mental health diversion denied because defendant does not meet the statutory requirements for eligibility under PC 1001.36(b)
- Number of petitions for mental health diversion denied because defendant does not meet the statutory requirements for eligibility under PC 1001.36(b) for individuals charged with at least one felony
- Number of pretrial mental health diversion petitions in which the individual successfully completed diversion
- Number of pretrial mental health diversion petitions in which the individual successfully completed diversion for individuals charged with at least one felony

Judicial Council Data Collection Challenges

Data collected during the first quarter of 2020 (the first period for which the reporting of this data was mandatory for courts) reflected activity which corresponded with the initial weeks of the COVID-19 shelter-in-place (SIP) order in California. This, in addition to subsequent orders of similar suit and the closure of many court buildings, meant superior court staff across much of the state may not have had the opportunity to access the data systems or set up the queries required to report these data to the Judicial Council. The data for these petitions and programs reported therefore should not be interpreted as a comprehensive count of statewide totals but rather a subset of them. Finally, this data may not have been as thoroughly validated as it would have been given the usual circumstances and as such may be subject to future changes.

DSH Data Collection Methodology

Pursuant to WIC 4361, counties funded by DSH for a felony mental health Diversion program are required to submit quarterly data reports that capture the following information:

- The number of individuals court ordered to post-booking diversion and the length of time for which the defendant has been ordered to diversion
- The number of individuals originally declared incompetent to stand trial on felony charges ultimately ordered to diversion
- The number of individuals participating in diversion
- The name, social security number, date of birth, and demographics of each individual participating in the program[1]
- The length of time in diversion for each participating individual
- The types of services and supports provided to each individual participating in diversion
- The number of days each individual was in jail prior to placement in diversion[1]
- The number of days that each individual spent in each level of care facility[1]
- The diagnoses of each individual participating in diversion[1]
- The nature of the charges for each individual participating in diversion[1]
- The number of individuals who completed diversion
- The name, social security number, and birthdate of each individual who did not complete diversion and the reasons for not completing

DSH operationalized the collection of these data points via a master data dictionary and workbook. As counties complete the contracting process with DSH, the DSH data team collaborates with the county data teams to individualize the master data dictionary and workbook for each county. Typically, adjustments to the data dictionary occur in the section capturing services provided as each program has a different combination of available treatment opportunities.

Once counties begin to send defendants to Diversion, they have 90 days after the end of each quarter to submit data reports to DSH. DSH provides each county with access to a secure online file transfer system to upload reports. DSH established reporting quarters in alignment with the state fiscal year (FY):

- Quarter 1 – July 1 through September 30
- Quarter 2 – October 1 through December 31
- Quarter 3 – January 1 through March 31
- Quarter 4 – April 1 through June 30

[1] This information shall be confidential and shall not be open to public inspection

Data Collection Challenges

DSH has encountered two main issues related to the collection of data for this project to date. The first issue is challenges to DSH's authority to collect patient-level data from various County Counsels and county information security departments. DSH released a Department Letter (DL 19-001) in October 2019 establishing its authority to collect this information as a "health oversight agency" as defined by the Health Insurance Portability and Accountability Act of 1996 (42 C.F.R. part 164.501) and as a program evaluator and auditor per 42 C.F.R. part 2.53. Clarifying this authority to the counties allowed DSH to require the submission of patient-level mental health and substance use disorder treatment for the purposes of evaluating these programs.

In FY 2019-20, data collection for this program was also impacted by COVID-19. Numerous counties which had planned to activate programs and begin diverting individuals before June 30, 2020, were delayed due to the numerous impacts of the pandemic, including court closures, and resource constraints in the county, mass releases of inmates at the local jails and virus outbreaks at the jails. These delays reduced the number of counties reporting to DSH in FY 2019-20. As of Fall 2022, all current DSH-contracted programs have been activated and reported data as of June 30, 2023.

SUMMARY OF REPORTED DATA

The following tables display high-level summaries of the data reported to DSH and the Judicial Council per the requirements of the above referenced Provisional Language.

FY 2018-19

DSH began collecting county data in FY 2018-19 as the first two county programs activated. The Judicial Council, however, was not required to collect data from counties prior to Quarter 1 of FY 2019-20.

FY 2018-19 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	N/A
PC 1001.36 Petitions Received (Felony)	N/A
PC 1001.36 Petitions Granted	N/A
PC 1001.36 Petitions Granted (Felony)	N/A
PC 1001.36 Petitions Denied	N/A
PC 1001.36 Petitions Denied (Felony)	N/A
PC 1001.36 Petitions Denied due to Statute	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A
PC 1001.36 Successful Completions	N/A
PC 1001.36 Successful Completions (Felony)	N/A
PC 1001.36 Unsuccessful Terminations	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	34
WIC 4361 Diversion Started	29
WIC 4361 Unsuccessful Terminations	0
WIC 4361 Successful Completions	0

FY 2019-20

During this period DSH collected data on existing programs and activated three additional county programs. The Judicial Council officially began collecting data in the third quarter of the fiscal year. However, courts were able to voluntarily submit data prior to the required compliance date.

FY 2019-20 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	1,924
PC 1001.36 Petitions Received (Felony)	563
PC 1001.36 Petitions Granted	680
PC 1001.36 Petitions Granted (Felony)	222
PC 1001.36 Petitions Denied	246
PC 1001.36 Petitions Denied (Felony)	99
PC 1001.36 Petitions Denied due to Statute	93
PC 1001.36 Petitions Denied due to Statute (Felony)	48
PC 1001.36 Successful Completions	78
PC 1001.36 Successful Completions (Felony)	30
PC 1001.36 Unsuccessful Terminations	62
PC 1001.36 Unsuccessful Terminations (Felony)	7
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	114
WIC 4361 Diversion Started	115
WIC 4361 Unsuccessful Terminations	< 11
WIC 4361 Successful Completions	0

FY 2020-21

DSH collected data throughout the fiscal year and activated three additional county programs. All 24 contracted programs activated by Spring 2021 and all programs reported data by Quarter 4 (April-June).

FY 2020-21 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	2,246
PC 1001.36 Petitions Received (Felony)	1,312
PC 1001.36 Petitions Granted	1,415
PC 1001.36 Petitions Granted (Felony)	624
PC 1001.36 Petitions Denied	735
PC 1001.36 Petitions Denied (Felony)	455
PC 1001.36 Petitions Denied due to Statute	413
PC 1001.36 Petitions Denied due to Statute (Felony)	269
PC 1001.36 Successful Completions	658
PC 1001.36 Successful Completions (Felony)	219
PC 1001.36 Unsuccessful Terminations	164
PC 1001.36 Unsuccessful Terminations (Felony)	86
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	258
WIC 4361 Diversion Started	259
WIC 4361 Unsuccessful Terminations	38
WIC 4361 Successful Completions	44

FY 2021-22

DSH collected data throughout the fiscal year. All 24 contracted programs reported data through Quarter 4 (April-June) of 2022.

FY 2021-22 Totals*	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	4,078
PC 1001.36 Petitions Received (Felony)	2,303
PC 1001.36 Petitions Granted	2,676
PC 1001.36 Petitions Granted (Felony)	1,455
PC 1001.36 Petitions Denied	980
PC 1001.36 Petitions Denied (Felony)	577
PC 1001.36 Petitions Denied due to Statute	507
PC 1001.36 Petitions Denied due to Statute (Felony)	294
PC 1001.36 Successful Completions	1,011
PC 1001.36 Successful Completions (Felony)	322
PC 1001.36 Unsuccessful Terminations	293
PC 1001.36 Unsuccessful Terminations (Felony)	151
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	409
WIC 4361 Diversion Started	389
WIC 4361 Unsuccessful Terminations	134
WIC 4361 Successful Completions	116

*FY 2021-22 Totals have been updated following receipt of updated data for this reporting period from the Judicial Council and DSH County programs.

FY 2022-23

DSH collected data throughout the fiscal year and activated five additional county programs. All 29 contracted programs activated by Fall 2022 and 23 contracted programs reported data through Quarter 4 (April-June) of FY 2022-23.

FY 2022-23 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	5,289
PC 1001.36 Petitions Received (Felony)	2,839
PC 1001.36 Petitions Granted	3,313
PC 1001.36 Petitions Granted (Felony)	1,634
PC 1001.36 Petitions Denied	815
PC 1001.36 Petitions Denied (Felony)	467
PC 1001.36 Petitions Denied due to Statute	455
PC 1001.36 Petitions Denied due to Statute (Felony)	273
PC 1001.36 Successful Completions	1,140
PC 1001.36 Successful Completions (Felony)	405
PC 1001.36 Unsuccessful Terminations	472
PC 1001.36 Unsuccessful Terminations (Felony)	208
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	576
WIC 4361 Diversion Started	620
WIC 4361 Unsuccessful Terminations	210
WIC 4361 Successful Completions	159

Number of Counties Reporting by Quarter

The first table below provides a summary of the total number of counties reporting data each quarter. The following tables display a more detailed count of the total number of counties reporting on each data element by fiscal year quarter, from 2018-19 through 2022-23.

Summary of Total Counties Reporting		
Numbers of Counties Reporting	**Judicial Council**	**DSH**
Q3 2018 (January - March)	**	2
Q4 2018 (April - June)	**	2
Q1 2019 (July through September)	25	3
Q2 2019 (October through December)	24	3
Q3 2020 (January through March)	40	4
Q4 2020 (April through June)	41	5
Q1 2020 (July through September)	43	11
Q2 2020 (October through December)	43	12
Q3 2021 (January through March)	44	19
Q4 2021 (April through June)	44	24
Q1 2021 (July through September)	49	24
Q2 2021 (October through December)	47	24
Q3 2022 (January through March)	49	24
Q4 2022 (April through June)	48	24
Q1 2023 (July through September)	47	24
Q2 2023 (October through December)	50	24
Q3 2023 (January through March)	48	23
Q4 2023 (April through June)	44	23

Fiscal Year 2018-19				
January - March 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	2	0	0	0
WIC 4361 Diversion Started	2	0	0	0
WIC 4361 Unsuccessful Terminations	2	0	0	0
WIC 4361 Successful Completions	2	0	0	0

April - June 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	2	0	0	0
WIC 4361 Diversion Started	2	0	0	0
WIC 4361 Unsuccessful Terminations	2	0	0	0
WIC 4361 Successful Completions	2	0	0	0

Fiscal Year 2019-20				
July - September 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	25	16	15	2
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	25	16	15	2
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	23	17	16	2
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	19	21	16	2
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	22	18	16	2
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	22	18	16	2
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	3	0	0	0
WIC 4361 Diversion Started	3	0	0	0
WIC 4361 Unsuccessful Terminations	3	0	0	0
WIC 4361 Successful Completions	3	0	0	0

October - December 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	25	16	16	1
PC 1001.36 Petitions Received (Felony)	25	16	16	1
PC 1001.36 Petitions Granted	24	16	17	1
PC 1001.36 Petitions Granted (Felony)	24	16	17	1
PC 1001.36 Petitions Denied	23	17	17	1
PC 1001.36 Petitions Denied (Felony)	23	17	17	1
PC 1001.36 Petitions Denied due to Statute	21	19	17	1
PC 1001.36 Petitions Denied due to Statute (Felony)	20	20	17	1
PC 1001.36 Successful Completions	24	16	17	1
PC 1001.36 Successful Completions (Felony)	24	16	17	1
PC 1001.36 Unsuccessful Terminations	22	18	17	1
PC 1001.36 Unsuccessful Terminations (Felony)	22	18	17	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	3	0	0	0
WIC 4361 Diversion Started	3	0	0	0
WIC 4361 Unsuccessful Terminations	3	0	0	0
WIC 4361 Successful Completions	3	0	0	0

January - March 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	40	11	7	0
PC 1001.36 Petitions Received (Felony)	39	12	7	0
PC 1001.36 Petitions Granted	40	10	8	0
PC 1001.36 Petitions Granted (Felony)	39	11	8	0
PC 1001.36 Petitions Denied	38	13	7	0
PC 1001.36 Petitions Denied (Felony)	37	13	8	0
PC 1001.36 Petitions Denied due to Statute	31	17	10	0
PC 1001.36 Petitions Denied due to Statute (Felony)	31	19	8	0
PC 1001.36 Successful Completions	39	11	8	0
PC 1001.36 Successful Completions (Felony)	39	11	8	0
PC 1001.36 Unsuccessful Terminations	38	12	8	0
PC 1001.36 Unsuccessful Terminations (Felony)	37	13	8	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	4	0	0	0
WIC 4361 Diversion Started	4	0	0	0
WIC 4361 Unsuccessful Terminations	4	0	0	0
WIC 4361 Successful Completions	4	0	0	0

April - June 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	8	7	2
PC 1001.36 Petitions Received (Felony)	40	9	7	2
PC 1001.36 Petitions Granted	41	8	7	2
PC 1001.36 Petitions Granted (Felony)	40	8	8	2
PC 1001.36 Petitions Denied	39	10	7	2
PC 1001.36 Petitions Denied (Felony)	38	11	7	2
PC 1001.36 Petitions Denied due to Statute	33	16	7	2
PC 1001.36 Petitions Denied due to Statute (Felony)	32	17	7	2
PC 1001.36 Successful Completions	40	8	8	2
PC 1001.36 Successful Completions (Felony)	40	8	8	2
PC 1001.36 Unsuccessful Terminations	40	9	7	2
PC 1001.36 Unsuccessful Terminations (Felony)	40	9	7	2
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	5	0	0	0
WIC 4361 Diversion Started	5	0	0	0
WIC 4361 Unsuccessful Terminations	5	0	0	0
WIC 4361 Successful Completions	5	0	0	0

Fiscal Year 2020-21				
July - September 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	10	4	3
PC 1001.36 Petitions Received (Felony)	40	11	4	3
PC 1001.36 Petitions Granted	43	8	4	3
PC 1001.36 Petitions Granted (Felony)	42	9	4	3
PC 1001.36 Petitions Denied	39	11	5	3
PC 1001.36 Petitions Denied (Felony)	40	11	4	3
PC 1001.36 Petitions Denied due to Statute	36	15	4	3
PC 1001.36 Petitions Denied due to Statute (Felony)	36	15	4	3
PC 1001.36 Successful Completions	41	10	4	3
PC 1001.36 Successful Completions (Felony)	39	11	5	3
PC 1001.36 Unsuccessful Terminations	41	9	5	3
PC 1001.36 Unsuccessful Terminations (Felony)	41	10	4	3
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	11	0	0	1
WIC 4361 Diversion Started	11	0	0	1
WIC 4361 Unsuccessful Terminations	11	0	0	1
WIC 4361 Successful Completions	11	0	0	1

October - December 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	13	3	1
PC 1001.36 Petitions Received (Felony)	40	14	3	1
PC 1001.36 Petitions Granted	43	11	3	1
PC 1001.36 Petitions Granted (Felony)	42	12	3	1
PC 1001.36 Petitions Denied	41	13	3	1
PC 1001.36 Petitions Denied (Felony)	40	14	3	1
PC 1001.36 Petitions Denied due to Statute	35	19	3	1
PC 1001.36 Petitions Denied due to Statute (Felony)	34	20	3	1
PC 1001.36 Successful Completions	41	13	3	1
PC 1001.36 Successful Completions (Felony)	40	14	3	1
PC 1001.36 Unsuccessful Terminations	41	13	3	1
PC 1001.36 Unsuccessful Terminations (Felony)	40	14	3	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	12	0	0	1
WIC 4361 Diversion Started	12	0	0	1
WIC 4361 Unsuccessful Terminations	12	0	0	1
WIC 4361 Successful Completions	12	0	0	1

January - March 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	43	11	4	0
PC 1001.36 Petitions Received (Felony)	41	13	4	0
PC 1001.36 Petitions Granted	44	10	4	0
PC 1001.36 Petitions Granted (Felony)	42	12	4	0
PC 1001.36 Petitions Denied	43	11	4	0
PC 1001.36 Petitions Denied (Felony)	41	13	4	0
PC 1001.36 Petitions Denied due to Statute	36	18	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	35	19	4	0
PC 1001.36 Successful Completions	43	11	4	0
PC 1001.36 Successful Completions (Felony)	41	13	4	0
PC 1001.36 Unsuccessful Terminations	43	11	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	41	13	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	19	0	0	0
WIC 4361 Diversion Started	19	0	0	0
WIC 4361 Unsuccessful Terminations	19	0	0	0
WIC 4361 Successful Completions	19	0	0	0

April - June 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	43	11	4	0
PC 1001.36 Petitions Received (Felony)	41	13	4	0
PC 1001.36 Petitions Granted	44	10	4	0
PC 1001.36 Petitions Granted (Felony)	43	11	4	0
PC 1001.36 Petitions Denied	41	12	5	0
PC 1001.36 Petitions Denied (Felony)	41	13	4	0
PC 1001.36 Petitions Denied due to Statute	36	18	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	35	18	5	0
PC 1001.36 Successful Completions	43	11	4	0
PC 1001.36 Successful Completions (Felony)	41	13	4	0
PC 1001.36 Unsuccessful Terminations	43	11	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	41	13	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

Fiscal Year 2021-22				
July - September 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	48	6	4	0
PC 1001.36 Petitions Received (Felony)	47	7	4	0
PC 1001.36 Petitions Granted	49	5	4	0
PC 1001.36 Petitions Granted (Felony)	47	7	4	0
PC 1001.36 Petitions Denied	46	8	4	0
PC 1001.36 Petitions Denied (Felony)	45	9	4	0
PC 1001.36 Petitions Denied due to Statute	42	12	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	41	13	4	0
PC 1001.36 Successful Completions	46	7	5	0
PC 1001.36 Successful Completions (Felony)	44	9	5	0
PC 1001.36 Unsuccessful Terminations	47	7	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	45	9	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

October - December 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	8	4	0
PC 1001.36 Petitions Received (Felony)	45	10	3	0
PC 1001.36 Petitions Granted	47	7	4	0
PC 1001.36 Petitions Granted (Felony)	45	9	4	0
PC 1001.36 Petitions Denied	45	9	4	0
PC 1001.36 Petitions Denied (Felony)	44	10	4	0
PC 1001.36 Petitions Denied due to Statute	40	14	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	39	15	4	0
PC 1001.36 Successful Completions	45	9	4	0
PC 1001.36 Successful Completions (Felony)	43	11	4	0
PC 1001.36 Unsuccessful Terminations	46	8	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	44	10	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

January - March 2022*				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	47	5	6	0
PC 1001.36 Petitions Received (Felony)	47	5	6	0
PC 1001.36 Petitions Granted	49	3	6	0
PC 1001.36 Petitions Granted (Felony)	48	4	6	0
PC 1001.36 Petitions Denied	46	6	6	0
PC 1001.36 Petitions Denied (Felony)	45	7	6	0
PC 1001.36 Petitions Denied due to Statute	42	10	6	0
PC 1001.36 Petitions Denied due to Statute (Felony)	41	11	6	0
PC 1001.36 Successful Completions	47	5	6	0
PC 1001.36 Successful Completions (Felony)	46	6	6	0
PC 1001.36 Unsuccessful Terminations	48	4	6	0
PC 1001.36 Unsuccessful Terminations (Felony)	46	5	7	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

*FY 2021-22 Totals have changed because the Judicial Council has provided updated data for this reporting period.

April - June 2022*				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	6	5	1
PC 1001.36 Petitions Received (Felony)	47	6	4	1
PC 1001.36 Petitions Granted	48	4	5	1
PC 1001.36 Petitions Granted (Felony)	46	6	5	1
PC 1001.36 Petitions Denied	46	6	5	1
PC 1001.36 Petitions Denied (Felony)	44	8	5	1
PC 1001.36 Petitions Denied due to Statute	41	11	5	1
PC 1001.36 Petitions Denied due to Statute (Felony)	40	12	5	1
PC 1001.36 Successful Completions	46	6	5	1
PC 1001.36 Successful Completions (Felony)	44	8	5	1
PC 1001.36 Unsuccessful Terminations	47	5	5	1
PC 1001.36 Unsuccessful Terminations (Felony)	45	7	5	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

*FY 2021-22 Totals have changed because the Judicial Council has provided updated data for this reporting period.

July-September 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	5	5	2
PC 1001.36 Petitions Received (Felony)	44	7	5	2
PC 1001.36 Petitions Granted	47	4	5	2
PC 1001.36 Petitions Granted (Felony)	45	6	5	2
PC 1001.36 Petitions Denied	44	7	5	2
PC 1001.36 Petitions Denied (Felony)	42	8	6	2
PC 1001.36 Petitions Denied due to Statute	38	13	5	2
PC 1001.36 Petitions Denied due to Statute (Felony)	37	14	5	2
PC 1001.36 Successful Completions	45	6	5	2
PC 1001.36 Successful Completions (Felony)	43	8	5	2
PC 1001.36 Unsuccessful Terminations	45	6	5	2
PC 1001.36 Unsuccessful Terminations (Felony)	43	8	5	2
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

October-December 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	47	3	7	1
PC 1001.36 Petitions Received (Felony)	47	4	6	1
PC 1001.36 Petitions Granted	50	1	6	1
PC 1001.36 Petitions Granted (Felony)	48	3	6	1
PC 1001.36 Petitions Denied	47	3	7	1
PC 1001.36 Petitions Denied (Felony)	45	5	7	1
PC 1001.36 Petitions Denied due to Statute	43	7	7	1
PC 1001.36 Petitions Denied due to Statute (Felony)	41	9	7	1
PC 1001.36 Successful Completions	48	3	6	1
PC 1001.36 Successful Completions (Felony)	45	5	7	1
PC 1001.36 Unsuccessful Terminations	47	3	7	1
PC 1001.36 Unsuccessful Terminations (Felony)	45	5	7	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item* Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	1	4
WIC 4361 Diversion Started	24	0	1	4
WIC 4361 Unsuccessful Terminations	24	0	1	4
WIC 4361 Successful Completions	24	0	1	4

*Data from Solano County was left blank due to discrepancies in data reporting.

January-March 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	3	5	4
PC 1001.36 Petitions Received (Felony)	46	4	4	4
PC 1001.36 Petitions Granted	48	1	5	4
PC 1001.36 Petitions Granted (Felony)	46	3	5	4
PC 1001.36 Petitions Denied	47	3	4	4
PC 1001.36 Petitions Denied (Felony)	45	5	4	4
PC 1001.36 Petitions Denied due to Statute	40	9	5	4
PC 1001.36 Petitions Denied due to Statute (Felony)	39	10	5	4
PC 1001.36 Successful Completions	46	3	5	4
PC 1001.36 Successful Completions (Felony)	44	5	5	4
PC 1001.36 Unsuccessful Terminations	45	4	5	4
PC 1001.36 Unsuccessful Terminations (Felony)	43	6	5	4
DSH Data*	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	23	0	0	5
WIC 4361 Diversion Started	23	0	0	5
WIC 4361 Unsuccessful Terminations	23	0	0	5
WIC 4361 Successful Completions	23	0	0	5

*DSH's contract with Santa Cruz County ended in Fall 2022. County no longer has an obligation to report data to DSH.

April-June 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	43	4	1	10
PC 1001.36 Petitions Received (Felony)	41	5	2	10
PC 1001.36 Petitions Granted	44	2	2	10
PC 1001.36 Petitions Granted (Felony)	42	4	2	10
PC 1001.36 Petitions Denied	42	4	2	10
PC 1001.36 Petitions Denied (Felony)	40	6	2	10
PC 1001.36 Petitions Denied due to Statute	36	10	2	10
PC 1001.36 Petitions Denied due to Statute (Felony)	35	11	2	10
PC 1001.36 Successful Completions	42	4	2	10
PC 1001.36 Successful Completions (Felony)	40	6	2	10
PC 1001.36 Unsuccessful Terminations	42	4	2	10
PC 1001.36 Unsuccessful Terminations (Felony)	40	6	2	10
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	23	0	0	5
WIC 4361 Diversion Started	23	0	0	5
WIC 4361 Unsuccessful Terminations	23	0	0	5
WIC 4361 Successful Completions	23	0	0	5

STATE HOSPITALS
MENTAL HEALTH SERVICES STAFFING
A Report to the Legislature in accordance with Chapter 38, Section 147, Provision 15 of Assembly Bill (AB) 102, Budget Act of 2023
Informational Only

EXECUTIVE SUMMARY

The Department of State Hospitals (DSH) Mental Health Services Staffing Report is enclosed. The report provides a detailed account of the DSH mental health services civil service staffing levels for its treatment team and level-of-care nursing, along with the usage of contractor staff. Additionally, the report includes details regarding DSH's recruitment and retention activities.

Data Collection

Classifications included in this report encompass all treatment team and level-of-care nursing utilized by DSH. A comprehensive listing of these classifications, corresponding bargaining units, minimum and maximum salaries, and other data points were derived from the State Controller's Office (SCO) Management Information Retrieval System (MIRS) used by State of California Human Resources staff, and the SCO Schedule 8 report prepared from the position and payroll rosters of all positions existing on June 30 of the immediate past fiscal year (2022-23).

DSH Mental Health Services Authorized Positions and Contractors for FY 2022-23

Attachment A displays information including the classifications that encompass the treatment team and level-of-care nursing categories. Within the treatment team category, roles included are psychiatrists, psychologists, rehabilitation therapists and social workers. The interdisciplinary treatment team works to develop a treatment plan and diagnosis, a plan for delivery of group treatment and as needed one-to-one treatment, sets treatment goals, coordinates discharge planning, and performs medication management. Currently, DSH caseload ratios for treatment team allocations are 1:15 for acute psychiatric level of care, 1:15 for Skilled Nursing Facility (SNF) care, 1:35 for intermediate care facility (ICF), 1:50 for residential recovery units (RRU), and one treatment team per unit, along with an additional psychologist and rehabilitation therapist, for the Enhanced Treatment Program (ETP) unit.

Roles within the level-of-care nursing category include registered nurses, licensed vocational nurses, and psychiatric technicians. Nursing services provide the essential 24-hour care necessary to treat and house patients with psychiatric needs. Nursing services involves observation and recording duties, medication and treatment delivery, identification of and response to emergency situations, safety and security roles, and assisting in the implementation of individualized patient treatment and

recovery plans. These roles consist of administration of medications, assessing patient behaviors and physical conditions utilizing provisions of care standards, supervising patient activities, providing escort services within and outside of the facility, assisting patients with activities of daily living, and implementing appropriate interventions identified by each patient's treatment and recovery plan. Nursing staff-to-patient ratios vary based upon the patient's level of acuity per DSH's adopted staffing standard and regulatory requirements. Currently, the minimum ratios for nursing allocations are: 1:6 on day and evening shifts and 1:12 on night shifts for units licensed as acute and SNF; 1:8 on day and evening shifts and 1:16 on night shift for units licensed as ICF; 1:13 for day, 1:17 for evening, and 1:32.5 on night shift for units licensed as residential recovery units RRU; and 1:1.5 for day, 1:1.5 for evening, and 1:3 for night shift for the Enhanced Treatment Program (ETP).

Throughout FY 2022-23, 169.8 of 1,062.3 total treatment team authorized civil service positions, or 16 percent, remained unfilled for all 12 months. During the same time, 557 of 4,959.9 total nursing category authorized civil service positions, or 11 percent, remained unfilled for all 12 months. This data highlights the challenges DSH faces in recruiting and retaining its mental health services team members.

Attachment A also shows that during FY 2022-23, DSH recorded a total of 246 vacated positions within the treatment team, and 1,190 vacated positions in the nursing department. With these vacated positions, DSH was able to fill 317 treatment team positions and 961 nursing positions with new hires. These figures provide insight into the turnover and dynamic nature of staffing within these critical healthcare roles, particularly during the COVID-19 pandemic. During 2022-23, DSH used Registered Nurse and Psychiatric Technician contractors to cover for staff absences and ensure adequate staffing levels for patient care. This was primarily in response to covering for nursing staff isolation or quarantine due to exposure to or contracting the COVID-19 virus, as well as coverage for staff vacancies.

Funding and Costs of Authorized Treatment Team and Nursing Positions in FY 2022-23

Funding allocated for authorized treatment team and level-of-care nursing amounted to roughly $934 million, consisting of authorized civil service salaries, benefits and funding for additional staffing due to COVID-19, while costs amounted to roughly $806 million, consisting of salaries paid to civil service positions and temporary help (i.e., retired annuitants, utilization of second positions, and establishment of an internal registry), along with benefits and overtime, resulting in a difference of $128 million due to vacancies. Of the $128 million, $47 million was returned to the Department of Finance through the Estimate, Caseload, and Population process due to delays in project implementation such as the DSH-Metropolitan Increased Secure Bed Capacity project and DSH-Patton Enhanced Treatment Program as well as delays in hiring associated with the Mission-Based-Review project. Due to the vacancy rates, DSH utilized $63 million of the difference

to meet patient care needs and mandated staffing ratios by delivering nursing and treatment team staffing to the units through contracted services. The remaining $18 million was utilized for one-time repair costs to assist in maintaining DSH's aging campuses.

Contractor Hours Worked and Costs in FY 2022-23

When hiring of civil services employees, overtime, and temporary help do not result in sufficient staffing to maintain service levels, DSH contracts for additional resources to maintain necessary staffing to provide medical and psychiatric care and treatment. In FY 2022-23, DSH utilized treatment team and level-of-care contractor resources to help deliver care and treatment to DSH patients. Treatment team contractors worked 135,930 hours (65.4 FTEs), with a corresponding expenditure of $39.3 million, including contractor salaries and administrative overhead. Concurrently, level-of-care nursing contractors contributed 240,305 hours (98.2 FTEs), with a total expenditure of $24.0 million. These figures reflect the department's use of contractors to maintain continuous service delivery. The allocation of vacant position salary savings, as well as having flexibility within DSH's operating expenditure budget, allowed the department to maintain mandated patient mental health services while also working and prioritizing to recruit permanent civil service team members.

Attachment A includes a comparison of hourly wages between paid contractors and State pay. Contractors are paid a higher hourly wage amount, however, DSH does not pay for contractor benefits as are paid with civil service team members (e.g., retirement, health, dental, vision and paid time off, along with the ability to telework). DSH diligently works to hire State civil service team members. However, when critical classifications are vacant, DSH must utilize contracted staff to ensure continuity of patient care.

DSH Recruitment and Retention Efforts

Recruitment and retention have been historically challenging for DSH and have only been exacerbated during the pandemic. While DSH is not alone in its staffing challenge for its health care workforce, DSH does present unique challenges for recruitment and retention due to multiple factors. The individuals DSH serves have some of the most difficult to treat behavioral health challenges, some with a significant violence risk level. This, coupled with the geographic locations of DSH's facilities and nationwide shortages for the healthcare workforce, makes recruitment and retention very challenging. Additionally, in response to ongoing litigation (*Coleman v. Newsom*) and associated court orders at the California Department of Corrections and Rehabilitation (CDCR), the mental health services staffing at CDCR are paid higher wages than DSH mental health services staffing. Generally, mental health services staffing at the prisons receive wages at least 5% greater than DSH. Mental health services staffing working in CDCR's psychiatric inpatient programs are

paid wages 20% higher than DSH's mental health services staffing. Due to these factors, DSH has implemented a multi-faceted approach to its efforts to recruit and retain team members, specifically focused across four domains: 1) marketing/outreach; 2) streamlining the hiring process; 3) developing and expanding training programs; and 4) employee compensation.

Marketing/Outreach

Historically, marketing and outreach methods included attendance at job fairs hosted by California State University (CSU) and University of California (UC), and other related job fairs as well statewide professional conferences. In recent years, DSH has expanded the use of these methods, as well as identified new innovative strategies to attract prospective candidates in hard-to-fill positions. A brief summary of the various efforts and outcomes from marketing and outreach efforts is provided below.

- DSH executed a contract with Cooperative Personnel Services Human Resources (CPSHR) to develop marketing and recruiting campaigns, focusing on increasing applicants for hard-to-recruit classifications with advertisements on social media platforms such as Facebook, Google Ads, Instagram, and YouTube. During this first phase, DSH focused on marketing and outreach for some specific classifications that include custodial, food service, and hospital police officer positions. Within the past few months this was expanded to include psychiatrist, psychologist, registered nurse (RN), and psychiatric technician (PT) classifications. This is in addition to continuing to leverage local and statewide advertising in traditional media and forums.
- DSH is partnering with the California Psychiatric Technician Education Program Directors to take recruitment efforts more "upstream" by building upon these relationships. The Psychiatric Technician pipeline expansion efforts consist of better aligning job employment efforts with concurrent advertisement of the educational programs for how to become a Psychiatric Technician. An online outreach and educational resource was established with materials for an overall outreach campaign to provide individuals a one-stop platform on how to become a Psychiatric Technician. This web resource went live on 09/25/23. Since then, that effort has generated 269 leads between the four colleges currently being hosted.
- Multiple Virtual Career Fairs have been hosted and onsite Career Fairs facilitated to increase opportunities for interested applicants to learn about DSH.
    - Earlier this year, DSH-Metropolitan and DSH-Coalinga hosted their own career fairs for all classifications. The two events attracted 259 candidates. Atascadero just held another in September. This is in addition to DSH's attendance at nearly 40 recruitment and outreach events over the past six months to increase awareness of DSH career opportunities.

  - Multiple Virtual Career Fairs were held with hundreds attending the sessions.
- DSH has extended its reach by partnering with other California State agencies such as the Employment Development Department (EDD), Department of Rehabilitation (DOR), and California Department of Human Resources (CalHR).
- DSH actively participated in health care-centered symposiums, professional mental health events like those organized by the Nursing Education Institute (NEI), and nursing conferences.
- DSH also explored professional publications for advertising and partnered with Regional Occupational Programs to establish an online platform to expand college program awareness and increase the department's visibility to psychiatric technician program candidates.

Removing Barriers to Employment

DSH has received feedback through the years that the state civil service hiring process can be challenging, particularly for candidates without prior public sector experience. The many steps and time it takes from application to hiring can be overwhelming for candidates. Sometimes they do not know how to get started, get discouraged along the way and ultimately do not complete the hiring process, or obtain employment faster from other organizations. To address these challenges, over the course of the past few months, DSH has implemented multiple strategies to remove barriers and streamlines processes for prospective candidates. A brief summary of efforts is highlighted below.

- DSH team members across administrative services and clinical disciplines have held one-day rapid hiring events intended to expedite the hiring process by providing contingent job offers the same day by helping candidates create their CalCareers account, develop the Std. 678- state application, apply, and take an exam. Some successful outcomes include:
  - DSH-Napa: 25 conditional job offers were made to nursing classifications in a single day event.
  - DSH-Patton: 74 conditional offers to Psychiatric Technicians in a single day event.
- Additionally, DSH Human Resources Office has partnered with local hospital HR teams and a variety of hospital subject matter experts to streamline exams, moving them to an online format. For example, CalHR is piloting a new exam administration and asked DSH to participate, which will allow exams to occur via self-certification with automatic results. This new examination process will be applied to psychology classifications, registered dieticians, and supervising social workers.
- DSH human resource leaders completed a review and assessment of the hiring process; reviewing each step to determine which were required and added

value versus those that did not. Recommendations are in the process of being implemented to streamline DSH's hiring process.

Growing its Own/Training Programs

One of DSH's proven recruitment methods has been through the development and implementation of various training programs across multiple clinical and nursing classifications. In recent years, DSH has invested resources to continue to expand on this best practice to grow its own workforce.

- Through support from the Legislature, DSH received resources in the 2023-24 budget for a new psychiatry residency program with dedicated training and fellowship slots at all five DSH locations, which is built on the successful development of a residency program at DSH-Napa. This proposal also provided resources to improve the continuing medical education process and opportunities. The development of a new psychiatry residency program at DSH-Patton is underway. Additionally, specific partnerships for fellowship and residency rotations scheduled to implement in early 2024 include:
    - Fellowship rotations with Stanford University at DSH-Atascadero, UCLA – at DSH-Metro, and UCSF at all facilities
    - Resident Rotations (1) - Kaiser Oakland at DSH-Napa
- In addition to developing the psychiatry pipeline, DSH continues to invest in developing its own team members through the expansion/offering of its hospitals' 20/20 training programs, which provides selected, qualified employees wishing to become Psychiatric Technicians and Registered Nurses the opportunity to participate in an approved full-time academic program while working half-time (generally 20 hours per week) in their current classification while receiving full pay and benefits.
- To prepare for future clinical and nursing leadership, DSH is implementing leadership training to promote professional development for Program Directors, Program Assistants, and Unit Supervisors.

Employee Compensation

DSH recognizes that compensation and benefits are a critical topic when discussing recruitment and retention of its workforce. While the California Department of Human Resources (CalHR) is the control agency who leads negotiations with the bargaining units when contracts are up for negotiation, DSH participates with CalHR in the collective bargaining process which has resulted in various compensation increases that are reflected in recent bargaining unit agreements. Specific compensation increases by bargaining unit agreement and classifications encompassed in this report are summarized below.

Bargaining Unit 16			Effective 7/1/2023
Class Code	**Classification**	**Adjustment Amount**	**Description**
7619	Staff Psychiatrist-Safety	3%	General Salary Increase
		15%	In-Person Differential for Psychiatrists
		1%	Pay Differential 324 – 1% recruitment and retention bonus payment and will increase 1% every year until year seven
		135%	Compensation of 135% of hourly rate for completing additional caseload beyond the normal caseload
		$10,000	Pay Differential 324 - One-Time Payment for Psychiatrist Classes if employee worked over 84 pay periods
		$1,000	Health Provider Recognition Payment

Bargaining Unit 17			Effective 7/1/2023
Class Code	**Classification**	**Adjustment Amount**	**Description**
8094	Registered Nurse-Safety	3%	General Salary Increase
		$1,450	Health Care Facility Retention Payment

Bargaining Unit 18			Effective 7/1/2022
Class Code	**Classification**	**Adjustment Amount**	**Description**
8253	Psych Techn-Safety	4%	4% Special Salary Adjustment at Maximum Salary
		1%	Pay Differential 463 - 1% Longevity Increase (20 or more years)

		$1,200	Pay Differential 462 - Mental Health and Wellness Stipend
		$400/$200	Monthly Recruitment and Retention Differential Stipends dependent on location $400 – Atascadero $200 – Coalinga, Metropolitan, and Napa

Bargaining Unit 19			**Effective 7/1/2023**
Class Code	**Classification**	**Adjustment Amount**	**Description**
8321	Rehab Therapist-Music-Safety	3%	General Salary Increase
		1.50%	Special Salary Adjustment
		8%	Special Salary Adjustment
		$1,450	Health Care Facility Retention Payment
		$500	Allowance for Required Continuing Education Units
8323	Rehab Therapist-Occ-Safety	3%	General Salary Increase
		4.35%	Special Salary Adjustment
		6%	Special Salary Adjustment
		$1,450	Health Care Facility Retention Payment
8324	Rehab Therapist-Recr-Safety	3%	General Salary Increase
		1.50%	Special Salary Adjustment
		8%	Special Salary Adjustment
		$1,450	Health Care Facility Retention Payment
8420	Rehab Therapist-Art-Safety	3%	General Salary Increase
		1.50%	Special Salary Adjustment
		8%	Special Salary Adjustment

		$1,450	Health Care Facility Retention Payment
		$500	Allowance for Required Continuing Education Units
9872	Clinical Soc Worker-HF/CF-Safety	3%	General Salary Increase
		3%	3% Special Salary Adjustment at Maximum Salary
		$10,000	Pay Differential 324 – One-Time Payment for Clinical Social Worker Classes if employee worked over 84 pay periods
		$1,450	Health Care Facility Retention Payment
9873	Psychologist-Clinical-Safety	3%	General Salary Increase
		10%	10% Special Salary Adjustment at Maximum Salary
		$10,000	Pay Differential 324 – One-Time Payment for Psychologist Classes
		$1,450	Health Care Facility Retention Payment
		Various	Additional Caseload Compensation

Bargaining Unit 20			**Effective 7/1/2023**
Class Code	**Classification**	**Adjustment Amount**	**Description**
8274	Licensed Voc Nurse-Safety	3%	General Salary Increase
		$1,450	Health Care Facility Retention Payment

Other Initiatives

In addition to the efforts outlined above, there are additional efforts that DSH also is implementing to demonstrate its commitment to overcoming the various workforce challenges.

- In an effort to retain treatment team and nursing team members, DSH has introduced flexible work options, including alternate work schedules and telework opportunities, recognizing the diverse needs of the workforce.
- DSH participates in an Advisory Group with Southern California community college consortium specific to Psychiatric Technician schools to promote DSH job opportunities.
- Additionally, DSH has implemented various support mechanisms for employees including an employee support line, post-incident support specialists, access to the California Chaplain Corps and Employee Assistance Program, and increased training on critical topics such as therapeutic options and trauma informed care.

Conclusion

A dedicated, caring, and passionate team of employees work at DSH to make a difference in the lives of individuals living with serious mental illnesses. To cultivate this team, the Department takes measures that extend beyond traditional approaches to recruiting and retaining civil service team members. DSH emphasizes a holistic approach to employee recruitment and retention by prioritizing safety, comprehensive support, and innovation to retain a highly qualified workforce. However, significant challenges related to the population served in DSH's hospitals, the geographic location of DSH hospitals, broader healthcare workforce shortages, and pay disparities between DSH and CDCR mental health services staff make recruitment and retention difficult.

Attachment A: Treatment Team and Level-of-Care Nursing Data (Fiscal Year 2022-23)

Attachment B: Average Length of Civil Service for Treatment Team and Level-of-Care Nursing Employees

Attachment C: Average Length Service for Treatment Team and Level-of-Care Nursing Contractors

Attachment A: Treatment Team and Level-of-Care Nursing Data (Fiscal Year 2022-23)

Treatment Team and Level-of-Care Nursing Position Data (Fiscal Year 2022-23)							
					A		B
Group Title	Class Code	Classification	Total Authorized[1]	Total Filled[2]	New Hires for 2022-23	Unfilled for 2022-23	Number of Separations
Clinical Services-Treatment Team							
	7619	Staff Psychiatrist-Safety	229.5	125.2	44.0	83.1	21.0
	8321	Rehab Therapist-Music-Safety	83.6	69.6	13.0	8.6	42.0
	8323	Rehab Therapist-Occ-Safety	5.0	3.2	1.0	2.0	11.0
	8324	Rehab Therapist-Recr-Safety	157.5	118.6	24.0	11.8	30.0
	8420	Rehab Therapist-Art-Safety	45.4	33.4	6.0	1.4	8.0
	8422	Rehab Therapist-Dance-Safety	7.0	2.7	1.0	2.0	1.0
	9872	Clinical Soc Worker-HF/CF-Safety	291.6	211.1	95.0	24.5	75.0
	9873	Psychologist-Clinical-Safety	242.7	161.0	133.0	36.4	58.0
Clinical Services-Treatment Team Total			**1,062.3**	**724.8**	**317.0**	**169.8**	**246.0**
Clinical Services-Nursing							
	8094	Registered Nurse-Safety	1,592.7	1,212.4	406.0	135.8	281.0
	8253	Psych Techn-Safety[3]	3,245.4	2,069.9	531.0	392.4	878.0
	8274	Licensed Voc Nurse-Safety	121.8	71.9	24.0	28.8	31.0
Clinical Services-Nursing Total			**4,959.9**	**3,354.2**	**961.0**	**557.0**	**1,190.0**
Grand Total			**6,022.2**	**4,079.0**	**1278.0**	**726.8**	**1,436.0**

[1] Total Authorized is derived from the Schedule 7A and is equal to Total Authorized Position Authority.
[2] Total Filled is derived from the Schedule 7A and is equal to the Full-Time Equivalent (FTE) of positions utilized in 2022-23. One FTE is equal to one full-time position working the entire year. If a position was only filled for 6 months in a year, the FTE equivalent would be 0.5.
[3] The Psychiatric Technician classification is an interchangeable classification with Psychiatric Technician Assistant and Senior Psychiatric Technician on the 7A, which is a point in time document. Vacant positions on the 7A for any of the three classifications will default to Psychiatric Technician.

A. New Hires and unfilled Authorized Positions for all of Fiscal Year 2022-23.
B. Number of separations for each classification in Fiscal Year 2022-23.

Treatment Team and Level-of-Care Nursing Position Data (Fiscal Year 2022-23)							
			C			D	E
Group Title	Class Code	Classification	Total Amount Funded (22-23)	Total Amount Spent (22-23)	Total Amount Unspent (22-23)	Amount of Contractor Hours	Amount Paid to Contractors Entities
Clinical Services-Treatment Team							
	7619	Staff Psychiatrist-Safety	$106,638,311	$66,278,534	$40,359,777	118,954.9	$37,444,844
	8321	Rehab Therapist-Music-Safety	$12,030,930	$10,250,456	$1,780,474	0.0	$0
	8323	Rehab Therapist-Occ-Safety	$686,026	$433,538	$252,488	0.0	$0
	8324	Rehab Therapist-Recr-Safety	$21,977,842	$17,470,549	$4,507,293	0.0	$0
	8420	Rehab Therapist-Art-Safety	$6,273,078	$4,874,750	$1,398,327	0.0	$0
	8422	Rehab Therapist-Dance-Safety	$937,906	$381,630	$556,276	0.0	$0
	9872	Clinical Soc Worker-HF/CF-Safety	$44,297,476	$33,534,132	$10,763,344	0.0	$0
	9873	Psychologist-Clinical-Safety	$45,181,392	$32,058,971	$13,122,421	16,975.0	$1,867,764
Clinical Services-Treatment Team Total			**$238,022,961**	**$165,282,561**	**$72,740,401**	**135,930.0**	**$39,312,608**
Clinical Services-Nursing							
	8094	Registered Nurse-Safety	$306,273,673	$295,078,393	$11,195,280	157,330.8	$18,563,338
	8253	Psych Techn-Safety	$376,655,070	$333,678,519	$42,976,551	24,935.3	$1,627,966
	8274	Licensed Voc Nurse-Safety	$12,795,522	$11,473,346	$1,322,176	58,039.1	$3,816,885
Clinical Services-Nursing Total			**$695,724,265**	**$640,230,258**	**$55,494,007**	**240,305.2**	**$24,008,189**
Grand Total			**$933,747,226**	**$805,512,818**	**$128,234,408**	**376,235.1**	**$63,320,797**

C. Total Amount Funded for positions (Civil Service Salaries, Benefits and COVID-19 Funding), total amount spent for positions (Paid Civil Services Salaries, Paid Temporary Help, Benefits and Overtime, and calculation for amount unspent for positions in Fiscal Year 2022-23.
   a. Of the $128 million, $47 million was returned to the Department of Finance through the Estimate, Caseload, and Population process due to delays in project implementation such as the DSH-Metropolitan Increased Secure Bed Capacity project and DSH-Patton Enhanced Treatment Program as well as delays in hiring associated with the Mission-Based-Review project.

D. Number of hours logged by treatment team and level-of-care nursing contractors in Fiscal Year 2022-23.

E. Amount paid to treatment team and level-of-care nursing contractors in Fiscal Year 2022-23.

Treatment Team and Level-of-Care Nursing Position Data (Fiscal Year 2022-23)									
			F						
Group Title	Class Code	Classification	Average Hourly Rate of Contractors	DSH 2022-23 Civil Service Pay Ranges	Average 2022-23 Hourly Civil Service Rate for DSH Employees	DSH 2023-24 Civil Service Pay Ranges	Average 2023-24 Hourly Civil Service Rate for DSH Employees	Safety Benefits (Medicare, Retirement, OPEB, and OASDI)	Average 2023-24 Hourly Civil Service Rate for DSH Employees with Benefits
Clinical Services-Treatment Team									
	7619	Staff Psychiatrist-Safety	$274.74	$22,115-$27,271	$183.96	$26,195-$32,303	$217.90	$72.45	$290.35
	8321	Rehab Therapist-Music-Safety	$0.00	$6,719-$7,913	$51.87	$7,586-$8,934	$58.57	$19.47	$78.04
	8323	Rehab Therapist-Occ-Safety	$0.00	$6,719-$7,913	$50.13	$7,655-$9,015	$57.12	$18.99	$76.11
	8324	Rehab Therapist-Recr-Safety	$0.00	$6,719-$7,913	$51.01	$7,586-$8,934	$57.60	$19.15	$76.75
	8420	Rehab Therapist-Art-Safety	$0.00	$6,719-$7,913	$51.95	$7,586-$8,934	$58.66	$19.50	$78.16
	8422	Rehab Therapist-Dance-Safety	$0.00	$6,719-$7,913	$51.95	$7,586-$8,934	$58.66	$19.50	$78.16
	9872	Clinical Soc Worker-HF/CF-Safety	$0.00	$6,658-$8,987	$56.55	$6,858-$9,534	$58.25	$19.37	$77.62
	9873	Psychologist-Clinical-Safety	$87.03	$8,420-$11,095	$70.58	$8,673-$12,571	$72.70	$24.17	$96.88
Clinical Services-Treatment Team Total									
Clinical Services-Nursing									
	8094	Registered Nurse-Safety	$100.76	$8,703-$10,373	$69.76	$8,964-$10,684	$71.85	$23.89	$95.74
	8253	Psych Techn-Safety	$53.50	$5,535-$6,539	$45.65	$5,635-$6,969	$46.33	$15.40	$61.73
	8274	Licensed Voc Nurse-Safety	$56.55	$4,560-$5,821	$39.80	$4,697-$5,996	$41.00	$13.63	$54.63
Clinical Services-Nursing Total									
Grand Total									

F. Contractors hourly wage in comparison to pay range of civil service classifications. Fiscal Year 2023-24 ranges calculated with recent bargaining unit agreements. Benefits also calculated into hourly rate (1.5% Medicare Taxation, 22.75% Retirement, 2.8% OPEB, and 6.2% OASDI).

Attachment B: Average Length of Civil Service for Treatment Team and Level-of-Care Nursing Employees

Average Length of Civil Service for Treatment Team and Level-of-Care Nursing Employees		
Classification	**Average Length of Civil Service**	
	Years	**Months**
Staff Psychiatrist (Safety) (7619)	8 years, 6 months	102
Psychologist (Health Facility – Clinical – Safety) (9873)	5 years, 6 months	66
Clinical Social Worker (Health/Correctional Facility - Safety) (9872)	7 years, 4 months	88
Registered Nurse (Safety) (8094)	8 years, 0 months	96
Psychiatric Technician (Safety) (8253)	9 years, 3 months	111
Licensed Vocational Nurse (Safety) (8274)	7 years, 2 months	86
Rehabilitation Therapist, State Facilities (Music – Safety) (8321)	9 years, 0 months	108
Rehabilitation Therapist, State Facilities (Occupational – Safety) (8323)	4 years, 6 months	54
Rehabilitation Therapist, State Facilities (Recreation – Safety) (8324)	9 years, 2 months	110
Rehabilitation Therapist, State Facilities (Art – Safety) (8420)	8 years, 2 months	98
Rehabilitation Therapist, State Facilities (Dance – Safety) (8422)	3 years, 0 months	36

Attachment C: Average Length Service for Treatment Team and Level-of-Care Nursing Contractors

Average Length of Contractors for Treatment Team and Level-of-Care Nursing Employees[1]		
Classification	**Average Length of Contracted Service**	
	Years	**Months**
Staff Psychiatrist (Safety) (7619)	1 year, 9 months	21
Psychologist (Health Facility – Clinical – Safety) (9873)	1 year, 0 months	12
Registered Nurse (Safety) (8094)	0 years, 5 months	5
Psychiatric Technician (Safety) (8253)	0 years, 8 months	8
Licensed Vocational Nurse (Safety) (8274)	0 years, 4 months	4

[1] Contracted employees' years and months of service are as provided by the contractor and reflect the average length of service under the current executed contract with DSH.